
The Relationship Between Medical Records and Hospital Accreditation: An Overview

Nasser Maqbul Binyah Alsharari¹, Saud Salamah Musallam Albalawi², Hamoud Alnaimi M Alruwaili³, Abdulelah Jabak A Alruwaili⁴, Sabah Abdulla Salamh Asslobi⁵, Saad Nasser R Alboqami⁶, Naji Dawash Naji Alreshidi⁷, Eid Abdullah Muhaysin Alrashdi⁸, Abdalellah Shadad Mhaya Alreshidi⁹, Mubarak Lafi Muaytig Al_Rashdi¹⁰.

¹ Technician Health, Administration, Al-Qurayyat Mental Health Hospital, Al-Qurayyat, Al-Jouf Region, Saudi Arabia.

² Health Information Technician, Tabuk Health Cluster - King Khalid Hospital, Civil Treatment Administration, Tabuk, Tabuk Region, Saudi Arabia.

³ Specialist-Health Administration, Al-Jouf Health Cluster - Suwair General Hospital, Sakaka, Al-Jouf Region, Saudi Arabia.

⁴ Specialist-Health Administration, Al-Jouf Health Cluster - Suwair General Hospital, Sakaka, Al-Jouf Region, Saudi Arabia.

⁵ Medical Records Technician, Turaif General Hospital, Turaif Governorate, Northern Borders Region, Saudi Arabia.

⁶ Health Administration and Community Health - Health Informatics, King Abdulaziz Specialist Hospital, Taif, Makkah Region, Saudi Arabia.

⁷ Health Administration, Faidat Athqab Health Center, Hail, Hail Region, Saudi Arabia.

⁸ Health Security, Faidat Athqab Health Center, Hail, Hail Region, Saudi Arabia.

⁹ Medical Records Technician, Lower Al-Halifa Health Center, Hail Region, Saudi Arabia.

¹⁰ Healthcare Management Hospital Management, Al-Hulayfah Al-Sufla Health Center, Hail Region, Saudi Arabia.

Abstract:

Medical records play a crucial role in hospital accreditation, serving as a primary source of information that reflects the quality of care provided to patients. Accreditation organizations, such as The Joint Commission and the National Committee for Quality Assurance, utilize medical records to evaluate compliance with established standards and guidelines. These records not only ensure patient safety and continuity of care but also demonstrate adherence to regulatory requirements. A well-maintained medical record system enhances the credibility of a hospital, as it provides a comprehensive view of patient history, diagnoses, treatments, and outcomes, which are essential for quality assessment and improvement initiatives required for accreditation. Furthermore, accredited hospitals often face rigorous standards that require systematic documentation of patient care processes. These standards encompass clinical guidelines, treatment protocols, and quality assurance measures. Accurate and complete medical records are critical for fulfilling these documentation requirements, allowing hospitals to exhibit their commitment to patient safety and quality improvement. In addition, effective use of electronic health records (EHR) systems can facilitate better data collection and reporting, which is essential for meeting accreditation standards and improving overall healthcare quality. Thus, the relationship between medical records and hospital accreditation is fundamental, as robust documentation practices not only support compliance but also enhance patient care outcomes.

Keywords: Medical records, hospital accreditation, quality of care, compliance, patient safety, treatment protocols, documentation practices, electronic health records, The Joint Commission, quality improvement.

Introduction:

The healthcare landscape is increasingly shaped by the dual forces of regulatory standards and the management of patient information. Among the essential components of this landscape is the

interplay between medical records and hospital accreditation. Hospital accreditation serves as a hallmark of quality healthcare provision, demonstrating compliance with established standards and regulations set forth by recognized

bodies. In contrast, medical records are pivotal in ensuring continuity of care, enhancing patient safety, and fostering effective communication among healthcare providers. Understanding the relationship between these two elements is not only crucial for healthcare administrators and practitioners but also for patients seeking quality care. This introduction aims to present an overview of how medical records contribute to, and are affected by, the processes of hospital accreditation [1].

Hospital accreditation is a formal recognition that a healthcare organization meets certain performance and quality standards. Accreditation bodies, such as The Joint Commission, the National Committee for Quality Assurance (NCQA), and the Healthcare Facilities Accreditation Program (HFAP), evaluate hospitals against specific criteria that encompass clinical performance, safety protocols, and operational efficiency. Achieving accreditation signifies that a hospital is committed to providing high-quality care and continuous improvement, instilling a sense of trust in patients and stakeholders alike [2].

The process of accreditation typically involves rigorous evaluations, site visits, and documentation reviews. Accredited hospitals often benefit from enhanced reputation, increased funding opportunities, and reduced liability risk, all of which are critical for sustainable operations in a highly competitive market. Moreover, accreditation can affect a hospital's status with insurance providers, in turn influencing reimbursement rates and financial stability. Thus, the implications of accreditation extend far beyond a simple certificate; they penetrate the operational and financial viability of healthcare institutions [3].

Medical records, which encompass a patient's comprehensive health information, including medical history, diagnoses, treatment plans, and outcomes, play an integral role in healthcare delivery. These records serve not only as documentation of care but also as tools for clinical decision-making, quality assurance, and performance evaluation. Accurate and accessible medical records facilitate effective communication among healthcare providers, thereby reducing the likelihood of errors, enhancing coordination of care, and improving patient outcomes [4].

In an era marked by digital transformation, electronic health records (EHRs) have evolved as a central repository of patient data, significantly influencing how medical information is managed and shared. EHRs provide a platform for real-time data access, enabling healthcare professionals to make informed decisions that are crucial for patient safety and quality of care. Furthermore, the interoperability of EHR systems is gaining prominence, as it allows different systems to communicate and share information seamlessly, echoing the need for integrated care delivery models [5].

The relationship between medical records and hospital accreditation is multifaceted and reciprocal. Accreditation standards often demand a high level of documentation and record-keeping practices, necessitating that hospitals maintain accurate, up-to-date medical records. While the specifics may vary by accrediting body, common standards require that medical records be comprehensive, secure, and accessible—qualities essential for demonstrating compliance with safety and quality metrics [6].

Accrediting organizations evaluate a hospital's adherence to protocols surrounding medical records during the accreditation process, focusing on critical areas such as documentation of care, informed consent, medication management, and confidentiality. For instance, standards may require hospitals to have well-defined policies for documenting patient interactions, including assessments, treatment strategies, and progress notes. Furthermore, adherence to these standards is closely linked to the hospital's ability to implement quality improvement initiatives, where medical records serve as a vital tool for tracking performance metrics, patient outcomes, and areas for improvement [7].

Conversely, the quality and management of medical records can significantly influence a hospital's accreditation status. Inadequate documentation, privacy breaches, or systemic issues related to record-keeping can lead to negative evaluations during accreditation reviews. As hospitals strive for accreditation, they often invest in training personnel, upgrading technology, and standardizing procedures related to medical records. This dynamic promotes not only the operational readiness of healthcare institutions but also enhances patient safety and quality of care [8].

Significance of Medical Records in Healthcare Settings:

In the expansive mosaic of modern healthcare, medical records stand out as one of the most crucial components. These records, often referred to as electronic health records (EHRs) or patient records, are comprehensive documents that gather health information about individuals and populations. The significance of medical records transcends mere documentation; they represent a backbone of healthcare operations, patient safety, legal compliance, and medical research [9].

At the heart of any healthcare system lies the commitment to patient care. Medical records serve as a vital tool for clinicians, offering a comprehensive picture of a patient's health history. This includes vital statistics, medical history, medications, allergies, immunizations, laboratory results, and imaging studies. Access to this information enables healthcare professionals to make informed decisions, reducing the risk of medical errors [9].

For instance, a complete medication list can prevent adverse drug interactions, a common issue that can lead to serious health complications. Furthermore, when physicians are aware of a patient's history of chronic illnesses, they can tailor treatment plans according to the patient's needs. Timely access to medical records is particularly crucial in emergency situations; when seconds count, having accurate information about a patient's health—such as existing conditions or allergies—can profoundly influence health outcomes [9].

In sum, thorough medical records contribute to enhanced patient safety by providing the necessary context for clinical decision-making, thereby enabling more personalized and effective care [10].

Another significant aspect of medical records is their role in facilitating communication and coordination among various healthcare providers. In today's increasingly complex healthcare landscape, patients often receive care from multiple specialists, primary care physicians, and ancillary services. Electronic health records enhance interoperability, allowing seamless sharing of information across different healthcare settings [10].

This interconnectedness is crucial in managing chronic diseases, where coordinated care among

various specialists is necessary to optimize treatment and prevent overlapping treatments. Moreover, consistent access to a patient's medical records fosters a holistic view of their health, thereby empowering providers to collaborate effectively. An integrated approach mitigates fragmentation of care, reduces duplication of tests, and can lead to more efficient healthcare delivery [11].

Medical records also play a fundamental role in ensuring legal compliance within healthcare settings. They serve as official documents that provide legal protection for both patients and healthcare providers. Accurate and timely documentation can be critical in cases of malpractice claims or audits. Health providers are obligated to maintain records that reflect the care delivered, including diagnostic codes, treatment plans, and patient consent forms [11].

In instances of legal disputes, comprehensive and well-kept medical records can serve as evidence to demonstrate that appropriate care was provided, safeguarding healthcare professionals from liability. Conversely, poorly organized or incomplete records can be detrimental, leading to potential legal repercussions for malpractice or negligence.

Moreover, medical records are governed by strict privacy regulations, such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States. This means that healthcare providers must ensure that records are not only comprehensive but also kept securely to protect patient confidentiality and data from unauthorized access. The ethical handling of medical records is essential to maintain the trust between patients and healthcare providers [12].

Beyond their significance at the individual patient level, medical records are invaluable for research and public health management. In clinical settings, aggregated data from medical records can help in identifying trends, evaluating intervention outcomes, and improving treatment protocols stemming from evidence-based practices. Researchers can utilize large datasets to identify risk factors, assess the effectiveness of new therapies, and contribute to the advancement of medical knowledge [12].

Public health organizations also rely on data derived from medical records to inform strategies for disease

prevention, health promotion, and health crisis management. During an outbreak, for instance, patient records can be used to analyze the spread of diseases and the demographic factors influencing it. This information can drive public health initiatives aimed at reducing incidence and optimizing resource allocation [12].

Moreover, with the rise of big data and machine learning, there is significant potential to harness medical records for predictive analytics. By examining patterns in large datasets, healthcare systems can proactively identify individuals at risk for certain conditions, enabling earlier intervention and potentially better health outcomes [13].

Key Accreditation Standards Related to Medical Documentation:

Medical documentation is a critical component of healthcare practice, serving as the backbone for communication between healthcare professionals, safeguarding patient safety, and ensuring compliance with legal and regulatory requirements. Accreditation standards established by various accrediting bodies outline the expectations and criteria necessary to maintain high-quality medical documentation [14].

The Importance of Medical Documentation

Medical documentation encompasses all written and electronic records that a healthcare provider generates while addressing a patient's care. This includes clinical notes, treatment plans, progress reports, diagnostic results, and discharge summaries, among other records. Accurate and comprehensive medical documentation is vital for various reasons:

1. **Patient Safety and Quality Care:** Proper documentation reflects the patient's medical history, treatment plan, and ongoing care. This information is crucial for ensuring the continuity of care, particularly when patients transition between different healthcare providers or facilities. Incomplete or inaccurate documentation can lead to medical errors, affecting patient outcomes [15].
2. **Legal and Regulatory Compliance:** Healthcare organizations operate in a complex legal environment. Medical documentation serves as a defense against

malpractice claims and regulatory scrutiny. Accurate and timely records are essential for adhering to the legal standards set forth in statutes and regulations.

3. **Billing and Reimbursement:** Effective medical documentation supports accurate billing and reimbursement processes. Payers, including insurance companies and Medicare, require detailed documentation to justify the medical necessity of services provided. Without proper documentation, healthcare organizations risk revenue loss and compliance issues.
4. **Quality Improvement and Patient Outcomes:** Accreditation bodies often utilize medical records in performance improvement initiatives. Consistent and reliable documentation allows healthcare organizations to analyze patient outcomes and identify opportunities for improving the quality of care provided [15].

Key Accreditation Standards Governing Medical Documentation

Several prominent accrediting bodies maintain specific standards concerning medical documentation. These bodies include The Joint Commission (TJC), the National Committee for Quality Assurance (NCQA), and the Centers for Medicare & Medicaid Services (CMS). Each organization has its own set of standards encompassing various aspects of medical documentation [16].

1. The Joint Commission (TJC)

The Joint Commission is one of the most recognized accrediting organizations in the healthcare field. Their standards emphasize the importance of complete and accurate medical documentation in their "Standards Manual," particularly in the following areas:

- **Patient Assessment and Care Planning:** TJC stipulates that healthcare organizations must create comprehensive assessments of each patient's needs, including their medical history, current health status, and treatment preferences. Documentation of the care planning process is mandatory, ensuring that care is

individualized and meets the patient's specific needs [16].

- **Medical Records Content:** According to TJC standards, each medical record must contain comprehensive documentation, including but not limited to demographic information, medical history, physical examination results, diagnostic information, assessment data, and treatment plans. This ensures that all relevant information is accessible to healthcare professionals involved in patient care.
- **Timeliness of Documentation:** Timeliness is critical in medical documentation. The Joint Commission requires that patient notes and relevant documentation be completed promptly following care delivery [17].
- **Retention and Accessibility:** TJC emphasizes the need for patient records to be maintained securely and confidentially for a prescribed duration, in accordance with legal and organizational policies. Accessibility for authorized personnel is also paramount to facilitate care and improve outcomes [17].

2. National Committee for Quality Assurance (NCQA)

The NCQA is primarily concerned with the quality of healthcare services delivered by organizations, especially managed care plans. Key standards regarding medical documentation include:

- **Clinical Record Keeping:** The NCQA requires that clinical records are organized and comprehensive, containing essential information about the patient's health and history. This includes clinical findings, treatment protocols, care plans, and follow-up care [18].
- **Care Coordination:** To improve continuity of care, the NCQA emphasizes that documentation must clearly illustrate inter-provider communications and care coordination efforts. This ensures that all healthcare providers involved in a patient's care have access to pertinent interventions, thereby enhancing patient outcomes.

- **Patient-Centric Documentation:** The NCQA encourages practices to involve patients in their care planning and documentation processes. This fosters better communication and engagement, which has been shown to improve overall satisfaction and compliance with care plans [18].

3. Centers for Medicare & Medicaid Services (CMS)

CMS oversees compliance for many federally funded healthcare programs. Their standards for medical documentation are primarily focused on reimbursement and quality of care:

- **Medical Necessity:** Documentation must provide comprehensive evidence of medical necessity for billed services. This includes clear details on diagnoses, treatment decisions, and the rationale for procedures performed [19].
- **Quality Audits and Reviews:** CMS facilities regular audits of medical records to ensure compliance with documentation standards. Disparities in documentation can result in withholding reimbursement, underscoring the need for attention to detail and adherence to regulations.
- **Patient Outcomes Reporting:** CMS maintains a focus on outcome reporting through measures linked to documentation practices. Healthcare providers must document ongoing performance metrics and patient outcomes as part of the quality assessment processes [19].

Implications for Healthcare Providers and Organizations

Healthcare organizations must prioritize adherence to accreditation standards in medical documentation for several key reasons:

1. **Risk Management:** By meeting accreditation standards, healthcare organizations mitigate risks associated with lawsuits, regulatory fines, and penalties. Proper documentation can serve as a protective mechanism, providing evidence of due diligence in patient care [20].

2. **Operational Efficiency:** Clear and structured documentation guidelines streamline workflows, allowing healthcare providers to allocate more time and resources to patient care rather than administrative functions.
3. **Patient Trust and Satisfaction:** Beyond regulatory compliance, establishing a reputation for thorough and accurate documentation enhances patient trust. When patients perceive that their providers are attentive and organized, their satisfaction with the care process increases.
4. **Financial Stability:** Accurate documentation directly affects an organization's revenue cycle. Attention to detail can prevent claim denials and ensure that organizations receive appropriate reimbursement for services rendered [20].

Impact of Electronic Health Records on Accreditation Processes:

The rapid evolution of healthcare technology, particularly the advent of Electronic Health Records (EHRs), has significantly reshaped the landscape of health service delivery, data management, and patient care. EHRs, which are digital versions of patients' paper charts, consolidate health information into a single record that is accessible and shareable across various healthcare settings. Given their increasing prevalence, it is essential to understand the broader implications of EHRs on accreditation processes within healthcare organizations. Accreditation serves as a quality assurance mechanism, ensuring that healthcare providers comply with established standards of care and operational efficiency [21].

One of the principal impacts of EHRs on accreditation processes is the enhancement of quality of care. Accreditation bodies, such as The Joint Commission and the National Committee for Quality Assurance (NCQA), emphasize quality metrics that healthcare organizations must meet to achieve accreditation. EHRs facilitate the collection, integration, and analysis of clinical data which, in turn, supports the measurement of patient outcomes and adherence to clinical guidelines [22].

Through EHR systems, healthcare providers can implement evidence-based practices by

automatically embedding clinical decision support tools. These tools guide practitioners in making informed decisions, aligning treatment protocols with the latest clinical guidelines. Notably, EHRs enhance the ability to track and monitor a range of quality indicators, such as medication errors, patient falls, and hospital readmissions, which are critical to the accreditation review process. As organizations actively engage in quality improvement initiatives driven by EHR analytics, they not only improve patient outcomes but also bolster their standing during accreditation evaluations.

In the realm of accreditation, compliance with laws and regulations concerning data security and patient privacy is crucial. The implementation of EHRs necessitates adherence to stringent regulations like the Health Insurance Portability and Accountability Act (HIPAA), which sets the standard for protecting sensitive patient information. Accreditation bodies often review how well organizations manage patient data, and the implementation of EHR systems can enhance this compliance [23].

EHRs contribute to improved data management through features such as user access logs, audit trails, and encryption, which help ensure that patient information is accessed and shared only by authorized personnel. Such functionalities help organizations demonstrate compliance with security standards required for accreditation. Furthermore, as EHRs reduce the reliance on paper-based records, they inherently minimize the risk of data loss or unauthorized access, adding an extra layer of security that aligns with the accreditation requirement for safeguarding patient information [24].

The transition from paper to electronic health records has streamlined many operational processes within healthcare organizations, allowing them to benefit from efficiencies that have a direct impact on accreditation. The automation of administrative functions such as appointment scheduling, billing, and documentation helps reduce human error and enhances workflow management [25].

Accreditation processes often require organizations to provide evidence of continuous quality improvement and operational performance. EHRs simplify the generation of reports and documentation needed for such evaluations. By capturing and organizing data in digital formats,

healthcare providers can produce performance reports effortlessly, allowing for timely communication with accreditation bodies. This not only augments an organization's ability to respond to accreditation surveys but also highlights its commitment to operational excellence.

Accreditation processes increasingly focus on the demonstration of quality improvement initiatives through performance measurement and reporting. EHRs are essential tools in this regard, as they enable healthcare organizations to collect and analyze data effectively, providing insights into areas that require attention [26].

Accrediting bodies often require healthcare organizations to track specific metrics, such as patient satisfaction scores or treatment efficacy rates. EHR systems can harness real-time data, capturing patient interactions and outcomes efficiently. The ability to track metrics over time facilitates the identification of trends, enabling organizations to implement targeted interventions aimed at improvement. Accreditation processes benefit from these capabilities, as organizations can readily present evidence of their quality improvement efforts, thereby heightening their chances of securing or maintaining accreditation [27].

While the impact of EHRs on accreditation processes appears overwhelmingly positive, it is essential to consider potential challenges. The initial implementation of EHR systems can be costly and resource-intensive, requiring significant investment in training, infrastructure, and ongoing maintenance. In some cases, poor implementation can lead to workflow disruptions that may hinder productivity. Additionally, the transition to EHRs requires cultural shift within organizations, as staff must adapt to new systems and protocols.

Moreover, the overwhelming amount of data generated by EHRs can lead to information overload, complicating efforts to extract actionable insights. Organizations must be strategic in determining what data to monitor and how to leverage it for quality improvement and accreditation purposes. It is crucial for healthcare providers to develop strong internal governance policies that ensure data integrity and relevance to accreditation standards [28].

Role of Medical Records in Quality Improvement Initiatives:

In the rapidly evolving landscape of healthcare, the emphasis on quality improvement has become paramount. Organizations are increasingly recognizing that delivering high-quality care is not only a professional obligation but also an essential component of operational effectiveness and patient safety. Central to these quality improvement initiatives are medical records — comprehensive collections of patient information that provide a foundation for clinical decision-making, research, and policy development [29].

Medical records are essential documents that contain detailed information regarding a patient's medical history, treatment plans, diagnostic tests, medication administration, and progress notes across various healthcare interactions. They serve multiple purposes, including providing continuity of care, facilitating communication among healthcare providers, and acting as a legal document of care provided. Additionally, medical records are crucial for billing and insurance claims [30].

One of the primary functions of medical records in quality improvement is their ability to provide evidence-based data that can guide healthcare organizations in identifying areas that require enhancement. Quality improvement initiatives rely on accurate, reliable, and accessible data to assess the efficacy of current practices, identify gaps in care, and measure clinical outcomes. By analyzing medical records, healthcare providers can monitor patterns of care delivery, track patient outcomes, and evaluate the impact of different interventions, thus laying the groundwork for informed decision-making and strategic improvements [31].

Utilization of Medical Records in Quality Improvement Initiatives

1. **Data Collection and Reporting:** Quality improvement initiatives often start with the collection of data from medical records. This data can encompass a wide array of information, including patient demographics, comorbidities, treatment protocols, and clinical outcomes. Healthcare organizations utilize this data to create reports that highlight trends, track performance metrics, and benchmark against best practices. For instance, a

facility may analyze readmission rates for patients with heart failure by pulling data from medical records to assess which interventions were effective or ineffective [32].

2. **Performance Improvement:** Medical records play an instrumental role in performance improvement efforts. By reviewing the documentation related to various treatments and the outcomes associated with them, healthcare organizations can identify best practices and areas for improvement. This process of continuous quality improvement is essential in addressing inefficiencies, reducing variations in care, and enhancing overall patient outcomes. As a concrete example, a hospital may examine patient records to evaluate how different surgical teams manage postoperative care, leading to the development of standardized protocols that improve recovery times and reduce complications [32].
3. **Benchmarking and Accreditation:** Quality improvement initiatives often require organizations to benchmark their performance against established standards or against other organizations. Medical records provide the data needed for these comparisons. Many accrediting bodies, such as The Joint Commission, require healthcare organizations to demonstrate their adherence to safety and quality standards through the analysis of medical record data. By consistently reviewing and improving this data, healthcare facilities can maintain their accreditation status and demonstrate their commitment to quality care [33].
4. **Patient Safety and Risk Management:** Medical records are vital for enhancing patient safety and risk management efforts. By systematically analyzing adverse events or near-misses documented in medical records, healthcare providers can conduct thorough root cause analyses to identify underlying issues that led to these occurrences. This analysis can play a crucial role in developing targeted interventions aimed at reducing similar

incidents in future patient care, as seen in organizations that have adopted TeamSTEPPS or other safety initiatives based on data derived from medical records [34].

5. **Patient Engagement and Shared Decision Making:** The documentation in medical records can empower patients in their own care processes. By ensuring that patients have access to their medical records, healthcare providers can foster a culture of transparency and encourage patient engagement. Shared decision-making models that involve patients in their treatment plans can improve adherence and satisfaction. Furthermore, healthcare organizations may analyze patient-reported outcomes included in medical records to tailor their services to meet patient needs better [34].

Challenges in Optimizing Medical Records for Quality Improvement

Despite the potential of medical records in facilitating quality improvement, there are notable challenges associated with their management and optimization. One significant challenge is the issue of data accuracy and completeness. Incomplete or poorly documented records can lead to misguided conclusions about the quality of care provided and hinder the effectiveness of improvement initiatives. Healthcare organizations must invest in training staff to enhance documentation practices and promote a culture of accountability regarding record keeping [35].

Another challenge is the interoperability of electronic health record (EHR) systems. The proliferation of different EHR platforms has created silos of information, complicating the ability to aggregate and analyze data across systems. This lack of interoperability can hinder quality improvement efforts that require comprehensive population-level data.

Lastly, regulatory compliance adds a layer of complexity to the use of medical records. Organizations must navigate a myriad of laws, such as the Health Insurance Portability and Accountability Act (HIPAA), which governs the privacy and security of health information. Striking a balance between leveraging data for quality

improvement and maintaining patient confidentiality is an ongoing challenge for healthcare providers [35].

Challenges in Maintaining Accurate Medical Records for Accreditation:

In today's healthcare landscape, the maintenance of accurate medical records is paramount not only for patient care but also for institutional accreditation. Accreditation serves as a hallmark of quality assurance in healthcare, validating that organizations meet predefined standards of care. However, the process of maintaining accurate medical records—while ensuring compliance with various regulatory and accreditation requirements—presents a multitude of challenges [36].

One of the primary challenges in maintaining accurate medical records is the sheer complexity of the regulatory requirements that healthcare organizations must adhere to. Medical records are subject to a myriad of federal and state regulations, including the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), and guidelines set forth by the Joint Commission and other accrediting bodies. Each of these regulations has specific requirements regarding documentation, data retention, and patient privacy [37].

The constantly evolving nature of healthcare laws further exacerbates this issue. Healthcare providers must stay updated on changes to regulations, which can often be intricate and multifaceted. Non-compliance can lead to serious repercussions, including fines, loss of accreditation, and reputational damage. Thus, smaller healthcare organizations, which may lack the requisite administrative resources, find it particularly challenging to keep abreast of these requirements.

The integration of information technology in healthcare has revolutionized the way medical records are maintained; however, it has also introduced a new set of challenges. Electronic Health Records (EHRs) are now the standard for documenting patient care, yet the use of these systems can be paradoxical. On one hand, EHRs improve the accessibility and sharing of patient information; on the other hand, they can contribute to inaccuracies if not utilized correctly [38].

For instance, medical professionals may inadvertently enter erroneous information due to user error or system glitches. Additionally, the interoperability among various EHR systems can be limited. When patients transition from one healthcare provider to another, discrepancies may arise if their records cannot seamlessly be shared or if the receiving system is incompatible. These inconsistencies jeopardize the integrity of medical records and, consequently, the ability of healthcare organizations to fulfill accreditation standards [39].

Human factors also significantly impact the accuracy of medical records. Miscommunication among healthcare staff, heavy workloads, and inadequate training can all contribute to documentation errors. Clinicians are often under immense pressure to meet the demands of their roles, leading to rushed documentation practices that can result in incomplete or inaccurate entries.

Moreover, workflow inefficiencies can exacerbate the problem. In many healthcare settings, the process of charting patient information may not be streamlined. Time-consuming procedures or redundant documentation requirements can distract clinicians from ensuring accuracy and thoroughness in their notes. As a result, this can lead to critical pieces of patient information being overlooked, which not only impacts patient care but can also have repercussions during audits for accreditation [40].

Creating a culture of compliance within healthcare organizations is essential for improving the accuracy of medical records. Leadership must prioritize the importance of accurate documentation and invest in staff training and education programs that emphasize best practices in record-keeping. This involves fostering open communication and encouraging feedback regarding documentation practices [40].

Moreover, organizations must create systems that support compliance with regulatory requirements. For example, employing quality assurance teams tasked with regularly auditing medical records can help identify patterns of error or omission. By addressing these issues proactively, institutions can improve their documentation processes and ensure a higher likelihood of maintaining accreditation.

Strategies for Improvement

To tackle the various challenges related to maintaining accurate medical records for accreditation, healthcare organizations can implement several strategic measures:

1. **Training and Education:** Continuous education programs should be established to keep staff updated on regulatory changes, documentation standards, and EHR functionalities. Regular workshops can help reinforce the importance of accurate record-keeping [40].
2. **User-Friendly EHR Systems:** Healthcare organizations should invest in user-friendly EHR systems that facilitate ease of documentation. Training sessions on the specific platform used can help clinicians maximize its features while minimizing errors.
3. **Interdepartmental Communication:** Enhancing collaboration among different departments can help ensure that everyone is on the same page regarding documentation needs. Establishing a standard operating procedure for documentation across the organization can also reduce confusion [40].
4. **Streamlining Workflows:** Analyzing current workflows to identify bottlenecks or inefficiencies can help organizations streamline processes. Implementing changes to improve the flow of information can ultimately increase the accuracy of medical records.
5. **Regular Audits and Feedback:** Conducting periodic audits of medical records can help identify inaccuracies and areas for improvement. Providing constructive feedback to staff can also ensure continuous learning and adaptation [40].

Case Studies: Successful Integration of Medical Records in Accreditation:

The healthcare industry has seen remarkable transformations over the past few decades, particularly concerning the accurate and efficient management of medical records. One crucial aspect

of this evolution is the adoption of electronic health record (EHR) systems that streamline the way patient data is collected, stored, and accessed. The integration of medical records into healthcare accreditation processes has become a pivotal factor in driving quality improvement, compliance, and accountability. Accreditations from organizations such as The Joint Commission and the National Committee for Quality Assurance (NCQA) are essential markers of a healthcare institution's commitment to delivering high-quality services [41].

1. Case Study: Cleveland Clinic

Cleveland Clinic is renowned for its commitment to clinical excellence and innovation, making it a fitting subject for study in the realm of medical record integration with accreditation processes. In 2013, the Cleveland Clinic invested heavily in an EHR system designed to centralize patient information, streamline workflows, and enhance data analytics [42].

Prior to this integration, Cleveland Clinic faced challenges in meeting accreditation standards set forth by The Joint Commission. Electronic recordkeeping allowed for better compliance with important accreditation criteria, such as medication management and patient safety protocols. With the EHR system in place, Cleveland Clinic was able to automate the collection of clinical data, which facilitated the documentation needed for the accreditation process. The result was not only smoother accreditation due to readily accessible records but significant improvements in patient safety, with a reported decrease in medication errors by over 40% post-implementation [43].

Furthermore, the centralized medical records system allowed Cleveland Clinic to easily generate reports during accreditation audits, which helped streamline processes and reduce the administrative burden typically associated with compliance efforts. By seamlessly integrating medical records with accreditation initiatives, Cleveland Clinic did not just enhance its standing with accrediting bodies but also significantly improved patient care outcomes [43].

2. Case Study: Kaiser Permanente

Kaiser Permanente serves as a leading example of how effective integration of medical records

facilitates accreditation across a large, multi-state healthcare provider system. With a mission centered on preventive health and coordinated care, Kaiser Permanente's investment in its integrated EHR platform has transformed how it manages patient records and demonstrates compliance with accreditation standards [44].

Kaiser Permanente's EHR system enables the seamless sharing of patient information among its collective network of hospitals, outpatient facilities, and primary care physicians. This integration simplified the reporting procedures required for Joint Commission accreditation, allowing the organization to consistently document compliance with quality care standards in real time. Their approach to clinical quality measurements through EHR means that they could continuously demonstrate compliance rather than waiting until the accreditation cycle began.

Moreover, their proactive approach to integrating electronic health records with accreditation requirements resulted in tangible improvements. In one specific instance, Kaiser Permanente noted a nearly 25% improvement in diabetes management among its members, directly correlating to the implementation of data-driven quality initiatives facilitated by the data from their EHR system. The ease of monitoring and tracking quality measures has made it simpler not only to achieve accreditation but also to surpass standards in patient care [44].

3. Case Study: Massachusetts General Hospital (MGH)

Massachusetts General Hospital (MGH), a Harvard Medical School teaching hospital, exemplifies the successful integration of medical records in the accreditation process, especially following its transition to an integrated EHR system known as "Partners eCare". Implemented in 2015, this system was designed with both clinical and operational efficiencies in mind [45].

MGH's investment in this EHR technology aimed at enhancing patient safety and ensuring compliance with accreditation standards set by The Joint Commission. One major benefit derived from this integration was the facility's ability to retrieve thorough, accurate medical histories that had previously been assembled from paper charts and various disconnected systems. During the initial evaluation of the EHR system's performance in its

first accreditation cycle, MGH reported near-perfect compliance in several key areas, including medication reconciliation and infection control protocols.

The careful tracking of patient outcomes through the EHR system enabled MGH not only to comply with accreditation standards but also to enhance overall quality improvement initiatives. The hospital introduced data analytics tools that scrutinized compliance gaps that led to developing targeted quality improvement projects. As a result, MGH saw a considerable reduction in surgical site infections—a significant monitoring metric for accreditation—thus enhancing its credibility and value as a healthcare provider [45].

Future Trends in Medical Documentation and Hospital Accreditation:

The landscape of healthcare is continually evolving, influenced by advances in technology, regulatory changes, and the increasing demand for transparency and accountability. As systems adapt to these changes, the realms of medical documentation and hospital accreditation are poised for significant transformation. Understanding the future trends in these areas is essential for healthcare professionals, administrators, and policymakers, as they navigate the complexities of delivering quality patient care while ensuring compliance with new standards and regulations [46].

The Digital Transformation of Medical Documentation

One of the most significant trends affecting medical documentation is the ongoing digital transformation. Electronic Health Records (EHRs) have already revolutionized the way health information is recorded, stored, and shared. However, the future promises even more sophisticated developments [47].

1. **Interoperability and Data Exchange:** As more healthcare providers adopt EHR systems, the push for interoperability—allowing disparate health systems to communicate seamlessly—is intensifying. Future developments will likely involve standardized data formats and protocols that facilitate smooth information exchange across platforms.

2. The adoption of FHIR (Fast Healthcare Interoperability Resources) standards is a key initiative in this direction, promoting a more cohesive framework for data sharing.
3. **Artificial Intelligence and Machine Learning:** AI technologies are expected to play a significant role in medical documentation, automating processes such as data entry, coding, and analysis. Machine learning algorithms can assist in sifting through vast amounts of clinical data, identifying trends, and enhancing decision-making processes. The integration of AI in medical documentation can reduce clerical burdens on healthcare providers, dedicating more time to patient care and clinical decision-making [47].
4. **Real-Time Data Capture:** With the proliferation of wearable devices and mobile health applications, the ability to capture patient data in real-time is increasing. This shift towards continuous monitoring allows for more timely and accurate documentation, fostering a proactive approach to patient management. Future documentation practices will likely integrate these technologies, providing healthcare providers with an up-to-the-minute view of their patients' health status [48].
5. **Patient-Generated Data:** The rise of patient engagement technologies is enabling individuals to contribute to their health records actively. With the empowerment of patients through apps and platforms that facilitate self-reporting of health data, healthcare providers will increasingly incorporate this information into official documentation. This trend will not only improve the comprehensiveness of medical records but also enhance the patient-provider relationship, as patients feel more involved in their care [48].

Innovations in Hospital Accreditation

Hospital accreditation procedures are also undergoing a significant transformation, driven by changes in both regulatory requirements and the expectations of patients and payers alike.

1. **Patient-Centric Approaches:** Future accreditation frameworks will likely emphasize patient-centered care models. Accreditation bodies are increasingly recognizing the importance of patient experience, safety, and quality of care. This shift requires hospitals to demonstrate not only compliance with clinical guidelines but also to actively engage patients in their care processes, ensuring their voices are heard in the decision-making that affects their treatment [49].
2. **Value-Based Care:** The transition from fee-for-service to value-based care models necessitates new metrics for assessing hospital performance. Accreditation bodies are likely to incorporate quality metrics that reflect patient outcomes, cost-effectiveness, and overall value in their evaluation criteria. This transformation pushes hospitals to focus on delivering high-quality care while managing resources efficiently, aligning with broader healthcare reform initiatives [50].
3. **Continuous Accreditation:** Traditional accreditation cycles often involve periodic evaluations, which can allow deficiencies to persist for extended periods. A future trend may involve the implementation of continuous accreditation processes, encouraging hospitals to maintain standards of care consistently. This could be facilitated through real-time data tracking and analytics, allowing accreditation bodies to assess compliance continuously rather than at fixed intervals [51].
4. **Integration of Technology:** Accreditation processes will increasingly incorporate technology-driven assessment methods. The use of remote audits, for instance, can streamline the evaluation process, saving time and resources for both accrediting bodies and healthcare organizations. Online reporting tools, dashboards, and data analytics will provide enhanced visibility into compliance and performance metrics, enabling more informed decisions regarding accreditation status [52].

5. **Collaboration with Stakeholders:** The future of hospital accreditation will likely be characterized by greater collaboration among various stakeholders, including healthcare providers, accrediting organizations, patients, and payers. Engaging these groups in the accreditation process can yield valuable insights and ensure that standards align with the realities of patient care. Participatory approaches can enhance the relevance and efficacy of accreditation standards, driving improvements in healthcare quality [53].

Challenges Ahead

Despite these promising trends, several challenges lie ahead in the realms of medical documentation and hospital accreditation. Data security and privacy concerns remain paramount, especially with the increase in data sharing and the reliance on digital platforms. Ensuring compliance with regulations like HIPAA (Health Insurance Portability and Accountability Act) while remaining responsive to evolving technologies will be a delicate balancing act for healthcare organizations [54].

Moreover, keeping pace with rapid technological advancements can present significant hurdles, especially for smaller healthcare institutions that may lack the resources to invest in cutting-edge systems. Addressing disparities in access to technology and training will be essential to ensure that all hospitals can meet future accreditation standards [55].

Additionally, the challenge of ensuring the reliability and accuracy of AI tools in clinical settings cannot be understated. As technology takes on a greater role in documentation and decision-making, the medical community must remain vigilant to avoid biases and errors that could adversely affect patient outcomes [56].

Conclusion:

In conclusion, the relationship between medical records and hospital accreditation is integral to enhancing the quality of patient care and ensuring compliance with established healthcare standards. Accurate and comprehensive medical records serve as the backbone of effective healthcare delivery, providing essential data that informs clinical decision-making and supports quality improvement

initiatives. Accreditation bodies rely on these records to evaluate hospital performance, ultimately influencing patient safety and satisfaction outcomes.

As hospitals increasingly adopt electronic health records (EHRs), the capacity for efficient data management and reporting is significantly improved, making it easier to meet accreditation requirements. However, challenges remain, including ensuring the accuracy, security, and accessibility of medical records. Emphasizing robust documentation practices and embracing technological advancements will be crucial for healthcare organizations aiming for successful accreditation. As the healthcare landscape continues to evolve, a strong commitment to maintaining high standards in medical record-keeping will be paramount in achieving not only accreditation but also the overarching goal of delivering exceptional patient care.

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