Available Online: 10 February 2026 DOI: 10.54254/3049-5458/2026.31781

The impact of hospital accreditation on medical record retrieval in a certain hospital

Gaofei Hu, Yingjuan Gao, Xuan Chen*

Department of Quality Management, The Fourth Affiliated Hospital of Soochow University, Suzhou, China

*Corresponding Author. Email: 874509927@qq.com

Abstract. Objective To explore the causes of delayed medical record archiving in a certain hospital and propose corresponding improvement measures to support hospital accreditation. Methods Discharged medical records from May 2023 to April 2024 in the hospital were selected as the control group, and those from May 2024 to April 2025 as the observation group. Administrative functional departments were organized to analyze the 2-day archiving status of medical records in the control group and propose scientific and reasonable improvement strategies. Results The 2-day archiving rate of the observation group was 1.6% higher than that of the control group. The archiving status of surgical medical records was relatively poor. Conclusion Guided by hospital accreditation indicators, Multi-Disciplinary Team (MDT) collaboration among administrative departments can improve the 2-day archiving rate.

Keywords: hospital accreditation, medical records, archiving rate, retrieval, informatization

1. Introduction

Medical records are the most valuable information repository of a hospital, and medical record management is an indispensable business of the hospital. The analysis and data mining of medical record information are important bases for hospital medical evaluation and management decision-making. The timely retrieval of paper medical records is a prerequisite for the processing and utilization of medical record information, but the timeliness of retrieval is a common issue [1-4]. Hospital accreditation aims to scientifically and systematically evaluate the comprehensive strength of the hospital, and quantitative indicators and evaluation indicators provide a powerful starting point for the development and construction of the hospital. Since its operation in December 2019, the hospital is in the period of grade hospital accreditation. Combined with the accreditation requirements and actual work, the management of medical record retrieval has been further strengthened, and certain results have been achieved. The specific report is as follows.

2. Materials and methods

2.1. Source of data

Discharged medical records from May 2023 to April 2024 in the hospital were selected as the control group, and those from May 2024 to April 2025 as the observation group. The retrieval status of the two groups to the medical record room within 2 working days (including the day of discharge) was counted. 2-day archiving rate of discharged patients' medical records = number of discharged patients' medical records completed archiving within 2 working days / total number of discharged patients' medical records in the same period × 100% [5]. In case of holidays, retrieval shall be completed within 2 working days after the holiday.

2.2. Processing methods

The hospital successfully passed the third-level hospital classification accreditation in March 2023 and is about to meet the grade accreditation. During the hospital accreditation period, to further strengthen the 2-day archiving rate, an administrative MDT team was formed by the Department of Quality Management, Information Department, Medical Affairs Department, Organization and Personnel Department, Operations Management Office, Nursing Department, etc., to analyze the causes of delayed retrieval in the control group. Multiple problems affecting medical record retrieval were found, such as heavy clinical work, poor mastery of medical record writing by physicians, delayed return of special examination reports, and unreasonable reward and punishment systems, which is consistent with the report by Gu Yuting et al. [6]. Rectification measures were implemented in the observation group.

2.2.1. Clarify the responsible entity

Physicians and nurses sorted out their respective medical documents for discharged medical records, and finally, full-time nurses sorted them and submitted them to the medical record room for archiving. Full-time nurses are responsible for logging into the HIS system every day to check the report of medical records to be archived and supervise medical staff to sort them out. The medical record room checks the report of unarchived medical records every working day and contacts full-time nurses by phone and WeChat group. The medical record room arranges special personnel to receive medical records throughout the day and delays work by 30 minutes.

2.2.2. Strengthen management, improve assessment and situation notification

The detailed assessment contents are submitted to the Operations Management Office for inclusion in performance management and to the Medical Affairs Department for inclusion in professional title promotion management. Improving the enthusiasm of clinical medical staff for medical record management work and promoting the improvement of medical record management level are the most fundamental purposes of the reward and punishment mechanism [4]. At the same time, urge departments to carry out self-inspection and self-correction activities.

2.2.3. Improve medical staff's awareness

The Department of Quality Management and Medical Affairs Department organized medical staff to study the "Regulations on the Management of Medical Records in Medical Institutions", "Basic Norms for Medical Record Writing", 18 Core Systems for Medical Quality and Safety (hereinafter referred to as Core Systems), etc.; trained on the indicators and requirements of the "Implementation Rules for the Accreditation Standards of Third-Level General Hospitals in Jiangsu Province (2023 Edition)", so that they can understand the significance of medical records in medical quality and safety and management, and consciously do a good job in medical record writing and archiving [7]. The training should cover the basic contents, and at the same time,

aim at the new needs in management, keep pace with the times, and be implementable. Countermeasures should be proposed for common and individual problems to solve the actual problems of the hospital.

2.2.4. Information support

Maintain the medical record tracking system for electronic medical record reception to ensure its normal operation.

2.2.5. Timely sending of special auxiliary examination reports

Electronic versions of special examination, pathology and other reports are timely uploaded to the HIS system, and paper versions are delivered to clinical departments by special personnel, especially surgery, gastroenterology, respiratory medicine, etc.

2.2.6. Improve the echelon of clinical physicians

According to the workload and the number of physicians in clinical departments, the Organization and Personnel Department allocates human resources to relevant clinical departments.

2.3. Statistical methods

Statistical analysis was performed using SPSS 26.0. Count data were expressed as [n (%)], and t-test was used for comparison. A p value < 0.05 was considered statistically significant.

3. Results

3.1. Under the background of hospital accreditation

Through the collaboration of administrative MDT and medical staff, the 2-day archiving rate of the observation group was 1.6% higher than that of the control group. Statistical comparison showed no significant difference in the 2-day archiving rate between the two groups (p > 0.05), see Table 1. It is worth noting that the average length of hospital stay during the control group was 6.2 days, and that during the observation group was 6 days.

Table 1. 2-day archiving status of the two groups [n (%)]

Group	Number of Archived Copies	Number of Unarchived Copies Within 2 Days
Control Group	34,473 (98.1%)	651 (1.9%)
Observation Group	38,650 (99.7%)	121 (0.3%)

3.2. Unarchived medical records within 2 days in both groups were mainly from surgery

There was no significant difference between the groups (p > 0.05), see Table 2. Among them, obstetrics and gynecology, vascular surgery and interventional department, and pain department were the main ones. The reasons were considered to be the large number of surgical patients, high bed utilization rate, insufficient number of physicians in some departments, and the fact that surgeons paid less attention to medical records than internists, among which the hospitalization of obstetrics and gynecology patients was difficult to plan.

Table 2. Distribution of unarchived medical records within 2 days in the two groups [n (%)]

Group	Total Number of Unarchived Copies in Surgery	Total Number of Unarchived Copies in Internal Medicine
Control Group	439 (67.4%)	212 (32.6%)
Observation Group	68 (56.2%)	53 (43.8%)

4. Discussion

4.1. Promote evaluation through assessment and construction through evaluation

Previously, the 3-day archiving rate of discharged medical records was assessed, and now the 2-day archiving rate is assessed. Faced with the current situation of the iterative update and regular assessment of public hospital performance appraisal, hospital accreditation rules and medical record quality management and control indicators, a clear assessment plan provides a practical focus, putting forward higher requirements for hospital refined management and medical quality. Only through the collaboration of the whole hospital and continuous improvement of diagnosis and treatment service capabilities can the assessment be passed. By improving the quality of the 3-day archiving rate of discharged medical records, the hospital, aiming at the 2-day medical record archiving rate, collaborated with administrative MDT and clinical departments to deeply understand clinical needs and difficulties, and achieved good results, meeting the assessment requirements. Guided by policies, in the process of analyzing indicators, we can identify shortcomings in various aspects, implement rectification, and promote the construction of various departments.

4.2. Medical records reflect clinical diagnosis and treatment

Medical records are legal documents formed during the diagnosis and treatment process and have timeliness [8]. Medical records are written and sorted out by medical staff, so the study of core systems should be strengthened, such as the three-level ward round system, difficult case discussion system, preoperative discussion system, etc. The connotation and time points of key diagnosis and treatment behaviors should be grasped, and medical records should not be regarded as medical history memoirs, which would lead to the loss of authenticity and timeliness of medical records [9]. The effective implementation of core systems can prevent delayed medical record archiving caused by the connotation of medical records and signature review. With the support of informatization, key contents are structured, prompts for principled writing errors are provided, and medical record writing is assisted. Medical record archiving is not only the delivery of paper documents to the medical record room, but also the archiving of rigorous medical and legal documents. Medical record retrieval is a result, but the in-depth reasons are the reflection of the cooperation of various departments, the connotation of medical records, and hospital management.

4.3. Promote the layout of paperless medical records

Paperless medical records have advantages such as medical information sharing, improved work efficiency, and cost savings, and are an inevitable trend in the informatization process of modern hospitals [10], which is comparable to the leap from paper currency payment to electronic payment. Paperless medical records adopt electronic recording form, and are automatically sorted and archived to the medical record room through the system after the patient is discharged, eliminating intermediate links such as the delivery of pathology reports,

the printing, sorting and binding by medical staff, reducing the workload of medical staff in sorting out medical records [10], and shortening the archiving time. In the future, the application of medical record information in hospital management, medical insurance payment, scientific research and teaching will reach an unprecedented state with the support of paperless medical records. With the continuous advancement of the high-quality development of public hospitals, paperless medical records, as a core element, will become a key work of the hospital [11]. According to reports by Ji Bingxin and Zuo Haixia et al. [12, 13], there are certain difficulties in the timely archiving of electronic medical records, and the archiving rate can be effectively improved by strengthening publicity and education and supervision [12]. The consolidation of the timely archiving of paper medical records enables medical staff to fully grasp relevant norms and requirements, promotes close cooperation between medical staff and administrative departments, and provides a guarantee for the development of paperless hospitals. It is reported that the hospital is exploring and promoting this work to achieve good results in the future.

5. Conclusion

This study investigates the impact of hospital accreditation on the 2-day archiving rate of medical records in a certain hospital by comparing the medical record retrieval status of the control group (May 2023 - April 2024) and the observation group (May 2024 - April 2025). The main findings show that under the guidance of hospital accreditation indicators, the establishment of an administrative Multi-Disciplinary Team (MDT) and the implementation of targeted improvement measures (including clarifying responsible entities, strengthening assessment management, improving medical staff awareness, providing information support, ensuring timely delivery of special examination reports, and optimizing the clinical physician echelon) have effectively improved the 2-day medical record archiving rate, with the observation group achieving a 1.6% higher rate than the control group. In addition, the study also found that unarchived medical records within 2 days in both groups were mainly from surgical departments, which is related to factors such as the large workload of surgical departments, insufficient human resources in some departments, and insufficient attention paid by surgeons to medical record archiving. Overall, hospital accreditation plays a positive guiding role in standardizing medical record management and improving the timeliness of medical record retrieval; the collaborative management model of administrative MDT can provide effective support for improving medical record archiving efficiency, and targeted rectification for surgical departments is conducive to further promoting the quality of medical record management in the hospital.

References

[1] Li, L. N., Zhang, G. J., & Wang, Y. (2021). Strengthened management of paper inpatient medical record retrieval. *Chinese Medical Record, 22*(1), 7–10.

[2] Wang, S. J. (2020). Countermeasures for delayed medical record retrieval. *Chinese Medical Record, 21*(7), 11–12, 68.

[3] Liang, C. L., & Yang, W. S. (2019). A review of 11 papers on improving medical record archiving rate. *Modern Hospital, 19*(9), 1315–1317, 1320.

[4] Ma, J. H. (2020). Application of reward and punishment mechanism in medical record retrieval management. *Chinese Hospital Statistics, 27*(2), 147–148, 152.

[5] Jiangsu Provincial Health Commission. (2023). Implementation rules for the accreditation standards of third-level general hospitals in Jiangsu Province (2023 Edition).

[6] Gu, Y. T., Weng, J., & Peng, Z. G. (2021). Analysis of influencing factors of delayed archiving of internal medicine medical records. *Chinese Hospital Statistics, 28*(5), 447–451.

[7] Su, L. Y. (2019). Changes and reflections on the connotation of core systems for medical safety in third-level general hospitals. *Jiangsu Health Care Management, 30*(6), 723–725.

[8] Liu, A. M. (2009). Medical record informatics. People's Medical Publishing House.

[9] Xiao, X. J. (2022). Research on problems and countermeasures in hospital medical record management. *Smart Healthcare, 8*(21), 1–4.

[10] Shi, B., & Liu, C. L. (2019). Implementation and improvement of paperless medical records. *Chinese Medical Record, 20*(11), 1–2.

[11] Huang, C. Y., Shi, X. Y., & Yang, D. M. (2025). Analysis of difficulties in the completeness of paperless archiving of inpatient medical records. *Chinese Medical Record, 26*(5), 1–3.

[12] Ji, B. X., Meng, Y., Zhao, L., Wang, S., & Zhang, H. (2020). Discussion on methods to promote the timely archiving of electronic medical records. *Chinese Medical Record, 21*(9), 41–42, 81.

[13] Zuo, H. X. (2020). Application of paperless management system in medical record work. *Chinese Medical Record, 21*(7), 6–8.