TITLE: Documentation Requirements for the Medical Record

I. Purpose/Expected Outcome:
A. To ensure the documentation in the medical record meets generally accepted professional standards of documentation, specifically mandated regulatory, legal and/or accrediting standards and supports the documentation guidelines identified in the Medical Staff Rules and Regulations.
B. The purposes of the Medical Record are:
   1. To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.
   2. To document the patient’s medical evaluation, treatment and change in condition during the hospital stay or during an ambulatory care or emergency visit,
   3. To allow a determination as to what the patient’s condition was at a specific time,
   4. To permit review of the diagnostic and therapeutic procedures performed and the patient’s response to treatment,
   5. To assist in protecting the legal interest of the patient, hospital and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.
C. Charts will be completed within fifteen days according to Medical Staff Bylaws, Rules and Regulations. Records will be classified as delinquent if not completed in their entirety within fifteen days after the patient’s discharge. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient.

II. Definitions:
A. HIMS – Health Information Management Services
B. EMR - Electronic Medical Record
C. Authentication – The term “Authentication” means to establish authorship by written or electronic signature and shall consist of the practitioner’s name and professional title indicating the professional credential.
D. Physician/Practitioner – For the purposes of the policy, physician/practitioner includes physicians, dentists, and podiatrists, advanced practice nurses, physician assistants, and other credentialed practitioners who give orders, provide consultations and perform surgical procedures.

III. Policy:
A. It is the policy of Ogallala Community Hospital to provide a medical record of the patient that is a timely, meaningful, authentic, and legible description of the patient’s clinical condition and hospital course. The following documentation requirements have been developed for this purpose.
B. A medical record is established and maintained for each patient who has been treated or evaluated at Ogallala Community Hospital (OCH). The medical record, including electronic data and medical imaging are the property of OCH.

IV. Procedure/Interventions:
A. N/A

V. Procedural Documentation:
A. General Requirements:
   1. **Responsibility:** The attending physician is responsible for each patient’s medical record. The medical record must identify who has primary responsibility for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient’s record must be accurately dated, timed and individually authenticated by the responsible physician.
   2. **Legibility:** All practitioner entries in the record must be legible, pertinent, complete and current.
   3. **Information from Outside Sources:** Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to OCH and that are required for or directly related to the admission are made a part of the patient’s hospital record.
   4. **Abbreviations:** Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health’s policy “Medical Record Abbreviations and Symbols” List.
   5. **Counter-authentication (Endorsement):**
      a. **Physician Assistants/Nurse Practitioners/Residents in Training:** All documentation by the Physician Assistant/Nurse Practitioners/Residents in Training will be counter authenticated timely by the applicable supervising physician as required by hospital policy and/or state statute/regulation including admission History & Physicals, Discharge Summaries, and Emergency Department records.
      b. **Medical Students:**
         i. **1st & 2nd Year** - Access to view the patient chart only. May not document in the medical record.
         ii. **3rd & 4th Year** - Any and All documentation must be endorsed (countersigned, counter-authenticated) timely by the applicable supervising/sponsoring physician.
   6. **Confidentiality of Patients’ Medical Records:** The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Banner Health safeguards patients’ records against unauthorized disclosure and/or use, loss, defacement, and tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records constitutes grounds for disciplinary action.

**Passwords** - All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.
B. Medical Record Content

1. **Medical Record Documentation and Content**: The medical record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:
   a. The responsible practitioner to provide continuing care, determine later what the patient’s condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient’s response to treatment.
   b. A consultant to render an opinion after an examination of the patient and review of the health record.
   c. Another practitioner to assume care of the patient at any time.
   d. Retrieval of pertinent information required for utilization review and/or quality assurance activities.

C. DOCUMENTATION

1. **History & Physical**: A complete history and physical examination shall, in all cases be done no more than 7 days before or 24 hours after the admission of a patient. Physical examinations may be used from the previous hospitalization if the examination was within 30 days. Physical examinations may be accepted from a doctor’s office if the examination was done within 30 days of admission and meets the standards as defined by hospital policy and procedure. If the patient was transferred from another hospital, the physical examination may be accepted if done within the last 30 days provided they are updated within 24 hours of admission or registration by the attending physician. In the above three cases, the attending physician must validate the physical examination in the medical record (on the physical exam) by noting that there are no significant findings or changes and signs and dates the report.
   a. The Emergency Room documentation form may not be used as a History and Physical.
   b. A complete history and physical examination shall be recorded before the time stated for operation or the operation shall be canceled unless the attending surgeon indicates it is an emergency procedure.
   c. If the complete history and physical was dictated shortly before the operation, but not yet transcribed, the surgeon/physician will document that the history and physical has been dictated. A short H&P can be used for procedures using procedure/moderate sedation. No H&P is required for procedures using local sedation.
   d. The following procedures are considered invasive and must have an H&P:
      i. Main OR procedures
      ii. Ambulatory Surgeries
      iii. C-section deliveries/tubal ligations
      iv. Endoscopies
      v. Cardioversions
   e. The prenatal record may be substituted for a history and physical but an interval admission note must be documented that includes pertinent additions to the history and subsequent changes in the physical findings. In the event a prenatal record is not present, a complete history and physical must be provided.
   f. Histories and Physicals completed by a physician assistant or nurse practitioner will be counter-authenticated by their supervising physician.
      i. **Responsibility for H&P** – The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated timely by the attending physician. Dentists and podiatrists
are responsible for the part of their patients' H&P that relates to dentistry or podiatry, in addition to the medical history & physical

g. Guidelines for H&P
   i. Medical history
   ii. Chief complaint
   iii. History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status
   iv. Relevant past medical, family and/or social history appropriate to the patient's age.
   v. Review of body systems.
   vi. A list of current medications and dosages.
   vii. Any known allergies including past medication reactions and biological allergies
   viii. Existing co-morbid conditions
   ix. Physical examination: current physical assessment
   x. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
   xi. Initial plan: Statement of the course of action planned for the patient while in the Medical Center.

2. Operative Reports:
   A. Operative reports shall be dictated or documented immediately following surgery.
   B. Guidelines for content of an Operative report include:
      1. Post-operative diagnosis
      2. A detailed account of the findings
      3. Technical procedures used
      4. Specimens removed
      5. Estimated blood loss
      6. Name of the primary performing practitioner and any assistants
      7. The full report must be documented immediately, as well as the recording of a post-operative progress note to be made available in the record after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient.

   C. A post operative progress note will be documented immediately after surgery to include the post op diagnosis, surgeon, estimated blood loss, specimen(s), and procedure done.

3. Discharge/Death/Transfer Summaries:
   a. A discharge summary shall be documented or dictated on all medical records within fourteen days after the patient’s discharge. All summaries shall be authenticated by the responsible practitioner.
   b. Physician assistants and nurse practitioners may dictate or document discharge or transfer summaries. These must be counter-authenticated by the physician.
   c. Transfer Summaries are to be documented or dictated at the time of transfer.
   d. Documentation of Death - A death summary is required for all deaths regardless of length of stay and must be documented at the time of death but no later than 7 days thereafter by the responsible practitioner.
   e. Guidelines for Discharge Summary
      i. Reason for hospitalization
      ii. Concise summary of diagnoses including any complications or co-morbidity factors
      iii. Hospital course, including significant findings
      iv. Procedures performed and treatment rendered
      v. Patient’s condition on discharge (describing limitations)
      vi. Patients/Family instructions for continued care and/or follow-up
f. A final discharge progress note may be used in place of a formal discharge summary for inpatient stays less than 48 hours, observations, extended recovery, normal newborns and normal vaginal delivery cases.
   i. It should be documented immediately.
   ii. It should include the following:
       (i) Final diagnosis(es)
       (ii) Condition of patient
       (iii) Discharge instructions
       (iv) Follow-up care required

4. **Clinical Entries**:
   a. All clinical entries in the patient’s medical record shall be accurately dated, timed and authenticated.
   b. All verbal orders for treatment shall be authenticated by the responsible practitioner within 24 hours.
   c. Physician assistants and nurse practitioner may enter orders including admission orders. Orders do not require counter-authentication by the physician.
   d. Progress notes should be documented or dictated with a frequency that reflects appropriate attending involvement but at least every day. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before. Progress notes should describe not only the patient’s condition, but also include response to therapy.
      i. Admitting Note - The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

5. **Emergency Department Reports**:
   a. An ER Record is required for all visits.
   b. It is expected to be completed within 24 hours of discharge/disposition from the Emergency Department.
   c. Guidelines for Emergency Department Reports
      i. Time and means of arrival
      ii. Pertinent history of the illness or injury, including place of occurrence and physical findings including the patient’s vital signs and emergency care given to the patient prior to arrival, and those conditions present on admission
      iii. Clinical observations, including results of treatment
      iv. Diagnostic impressions
      v. Condition of the patient on discharge or transfer
      vi. Whether the patient left against medical advice
      vii. The conclusions at the termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services

6. **Consultations**: A satisfactory consultation includes examination of the patient as well as the medical record and should be documented or dictated within 24 hours. When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).

7. **Final Diagnosis**: Final Diagnosis shall be recorded in full without the use of symbols or abbreviations, dated, and signed by the responsible practitioner at the time of discharge of all patients.

8. **Pre-Operative Anesthesia/Sedation Evaluation**: A pre-anesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A pre-anesthesia evaluation of the patient must include pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic
problems, American Society of Anesthesiologists (ASA) patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the patient’s transfer to the operating area and before the pre-operative medication has been administered.

9. **Intraoperative & Post Anesthesia/Sedation Record:**
   a. An intraoperative anesthesia/sedation record will be maintained for each patient and include drugs/agents used, pertinent events during indications, maintenance of emergence from anesthesia/sedation, all other drugs, intravenous fluids and blood components given.
   b. Documentation in the post anesthesia/sedation care unit includes the patient’s level of consciousness upon entering and leaving the area, vital signs, and status of infusions, drains, tubes catheters and surgical dressing (when used), unusual events or complications and management.
   c. A post anesthesia/sedation evaluation for proper recovery of anesthesia/sedation must be completed and documented by an individual qualified to administer anesthesia/sedation within 48 hours after the procedure or prior to the patient being discharged or transferred from the post anesthesia/sedation care area regardless of type or location where anesthesia/sedation is performed.

10. **Informed Consent:** Prior to any operative procedures, the medical record must contain an informed consent as outlined in the medical staff Rules and Regulations.

11. **Special Procedures:** EEGs, EKGs, treadmill stress tests, echocardiograms, tissue, medical imaging, and other special procedure reports will be interpreted and documented within 24 hours of notice/communication to the physician or agent to inform the provider of the test completion.

**D. TIMELY COMPLETION**

1. **Complete Medical Record:** The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with this policy. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

2. **Timely Completion of Medical Record Documents:** All medical record documents shall be completed within time frames defined below:

<table>
<thead>
<tr>
<th>Documentation Requirement</th>
<th>Timeframe</th>
<th>Exclusions</th>
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</thead>
<tbody>
<tr>
<td>Emergency Department Report</td>
<td>Documented within 24 hours of discharge/disposition from the Emergency Department</td>
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<tr>
<td>Admitting Progress Note</td>
<td>Documented within 24 hours of admission</td>
<td></td>
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<tr>
<td>History &amp; Physical</td>
<td>Documented within 24 hours of admission and before invasive procedure</td>
<td>Must be completed prior to surgery</td>
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<td>No H&amp;P needed for local anesthesia</td>
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<td></td>
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<td>OB’s – may substitute prenatal – if turns into surgical, need H&amp;P prior to surgery</td>
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<tr>
<td>Consultation Reports</td>
<td>Documented within 24 hours of consultation</td>
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<tr>
<td>Post Op Progress Note</td>
<td>Documented immediately post op.</td>
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<tr>
<td>Provider Coding Query</td>
<td>Documented response no later than</td>
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<tr>
<td>Medical Record Requirement</td>
<td>Documentation Requirement</td>
<td>Notes</td>
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<tr>
<td>Operative Report</td>
<td>Immediately after the procedure</td>
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<tr>
<td>Special Procedures Report</td>
<td>Documented within 24 hours of completion of procedure</td>
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<tr>
<td>Discharge Summary Report</td>
<td>Documented at the time of discharge/disposition but no later than 7 days post discharge</td>
<td>Not required on all admissions less than 48 hours, or for normal vaginal deliveries and normal newborns</td>
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<tr>
<td>Discharge Progress Note</td>
<td>Documented at the time of discharge/disposition and no later than 7 days post discharge for all admissions less than 48 hours or for normal vaginal deliveries and normal newborns</td>
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<tr>
<td>Death Summary</td>
<td>Documented at the time of death/disposition but no later than 7 days post discharge</td>
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</tr>
<tr>
<td>Transfer Summary</td>
<td>Documented at the time of transfer</td>
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</tr>
<tr>
<td>Signatures</td>
<td>Authentication of transcribed or scanned reports and progress notes, within 15 days from the date of discharge.</td>
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<tr>
<td>Verbal Orders</td>
<td>Dated, time and authentication with 48 hours from order</td>
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3. **Medical Record Deficiencies:** Physicians are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has reached 15 days from the date the deficiency is assigned (allocation date). The notice will include a due date and a list of all incomplete and delinquent medical records. No additional notification is given.

   a. If a vacation prevents the practitioner from completing his/her medical records the physician must notify the Health Information Services Department in advance of the vacation; otherwise the suspension will remain in effect until the documentation is completed.
   b. If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician’s office must notify the Health Information Management Services Department.

E. **SUSPENSION**

1. **Medical Record Suspensions:** A medical record is considered eligible for suspension 22 days. If the delinquent records are not completed timely, providers will receive a notice and their admitting and surgical/procedure scheduling privileges will be temporarily suspended until all medical records are completed. A suspension list will be generated and distributed to the Medical Executive Committee, Administration, and applicable hospital departments. A notification will be sent to the above areas once the physician has completed all documentation requirements.

2. Medical record suspension includes loss of non-emergent Hospital privileges, including elective admissions, scheduling elective procedures, administering anesthesia, consultations and surgery assists. The suspended physician may request another physician with appropriate privileges to
assume his/her patient care duties. A suspended physician may not admit a patient under another physician’s name and then assume the patient’s care.

a. Exceptions: physicians under Medical Records Suspension shall continue to provide the following care:
   i. Routine care for his/her own patients already in the Hospital at the time of suspension. (Routine care does not include consultations, invasive procedures or surgery assist).
   ii. All ER Call Roster responsibilities. (If an ER patient under the care of a Medical Staff member under medical records suspension requires an emergency admission or procedure, the member shall promptly attend to the patient’s emergency needs.)

b. If a medical staff member remains on continuous medical record suspension for 40 days, the administrator will notify the physician, by certified letter, to complete all delinquent records within 7 days and if the records remain incomplete, that such physicians will be deemed to have voluntarily resigned from the medical staff and would have to reapply for membership and privileges.

c. Exception: Unforeseen circumstances such as illness, injury, military duty or other personal issue will be reviewed by the Chief of Staff and/or the hospital CEO.

VI. Additional Information:
   A. N/A

VII. References:
   A. N/A

VIII. Other Related Policies/Procedures
   A. N/A

IX. Keywords and Keyword Phrases
   A. Medical Staff
   B. Documentation in Medical Record
   C. Medical Record

X. Appendix:
   A. N/A