Community Health Network

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MEDICAL STAFF POLICIES & PROCEDURES

Applicability: **Community Hospital East, Community Heart and Vascular Hospital (A Department of Community Hospital East), Community Hospital North, Community Hospital South**

TITLE: Medical Record Chart Requirements

STATEMENT OF PURPOSE: The purpose of this policy is to define the requirements of the medical record including general documentation requirements and medical record content.

GENERAL INFORMATION:

The medical record shall contain sufficient information to:

1. Identify the patient
2. Support the diagnosis
3. Justify the treatment
4. Document accurately the course of treatment and results
5. All entries in the medical record shall be:
    a. Legible and complete
    b. Made only by individuals given this right as specified in hospital and medical staff policies
    c. Authenticated and dated promptly
6. All inpatient records shall document and contain:
    a. Identification data
    b. The medical history and physical examination of the patient done within the time frames as prescribed by the medical staff rules and hospital licensure rules
    c. A statement of the diagnosis or impressions drawn from the admission history and physical examination.
    d. Diagnostic and therapeutic orders
    e. Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy and consistent with federal and state law.
    f. Clinical observations, including results of therapy, documented in a timely manner.
    g. Progress notes
    h. Operative notes, if applicable.
    i. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
    j. Nursing notes, nursing plan of care, and entries by other health care providers that contain pertinent, meaningful observations, and information.
    k. Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures and their results.
    l. Documentation of complications and unfavorable reactions to drugs and anesthesia.
    m. A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn and uncomplicated obstetric delivery. The final progress note should include any instruction given to the patient and family.
    n. Final diagnosis

7. A short stay record form used for inpatients hospitalized for less than forty-eight (48) hours, observation patients, ambulatory care patients, and ambulatory surgery patient shall document and contain, but not limited to, the following:
    a. Identification data
    b. Medical history and description of the patient's condition and pertinent physical findings.
    c. Diagnostic and therapeutic orders
    d. Care based on identified standard of care and standard of practice.
    e. Data necessary to support the diagnosis and treatment given, with reports of procedures and tests, and their results, clinical observations, including the results of therapy, and anesthesia given, if applicable.
    f. Operative note, if applicable.
    g. Final progress note, including instructions to the patient and family with dismissal diagnosis and disposition of patient.
    h. Authentication by the physician and other responsible personnel in attendance.
8. Outpatient records shall document and contain, but not be limited to, the following:
    a. Identification data
    b. Diagnostic and therapeutic orders including reason for visit/chief complaint/diagnosis
    c. Description of treatment given, procedures performed, and documentation of patient response to intervention, if applicable.
    d. Results of diagnostic tests and examinations done, if applicable.
9. Emergency Department records shall document and contain, but not be limited to, the following:
    a. Identification data
    b. Time of arrival, means of arrival, time treatment is initiated, and time examined by the physician, if applicable.
    c. Pertinent history of illness or injury, description of the illness or injury, and examination, including vital signs.
    d. Diagnostic and therapeutic orders
    e. Description of treatment given or prescribed, clinical observations, including the results of treatment, and the reports of procedures and test results, if applicable.
    f. Authentication by the practitioner or licensed health professional who rendered treatment or prescribed for the patient in accordance with hospital policy.
    g. Instruction given to the patient on release, prescribed follow-up care, signature of patient or responsible other, and name of person giving instructions.
    h. Diagnostic impression and condition on discharge documented by the practitioner, and disposition of the patient and time of dismissal.
    i. Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient of if the patient is referred elsewhere, the reasons for such action shall be recorded.

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POLICY STATEMENTS:

All entries in the medical record must be legible, complete, dated, timed and authenticated either in written or electronic format. Documentation must be written in black ink and if documented electronically, black font should be used. Medical records shall be retained in their original or legally reproduced form as required by federal and state law. Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record. (410 IAC 15-1.5-4 Medical Record Services).

PROCEDURE:

The medical record shall contain sufficient information to meet all Accrediting and Regulatory requirements.

History and Physical (H&P) Requirements:

A) The patient shall receive a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting the review of the history and physical and any changes in the patient's condition must be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

The requirements for an update are as follows:

1. The patient must be re-examined documenting any necessary changes.
2. The history must be reviewed documenting any necessary changes.
3. At a minimum, the verbiage must include "The history and physical was reviewed, the patient was re-examined and any necessary changes have been documented."
4. Authentication, including signature, date and time of entry.

B) Responsibility of the H&P -See table Addendum A for co-signature requirements

1. Licensed physician
2. Nurse practitioner
3. Physician assistant
4. Resident

C) Content

History

1. Chief Complaint
2. Details of present illness
3. Medications
4. Allergies
5. Relevant past, social and family history
6. Existing co-morbid conditions

Physical

1. Inventory of body systems
2. Physical assessment
3. Statement of impressions/conclusions
4. Statement of course of action planned.

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Physical - Procedures

Topical, Local or Regional Block

1. Assessment of mental status
2. Examination specific to the procedure proposed to be performed and any comorbid conditions

IV Sedation

1. Assessment of mental status
2. Examination specific to the procedure proposed to be performed and any comorbid conditions
3. Examination of heart/lungs by auscultation

General, Spinal or Epidural

1. Assessment of mental status
2. Examination specific to the procedure proposed to be performed and any comorbid conditions
3. Examination of heart/lungs by auscultation
4. Assessment and written statement about the patient's general health

D) Non-operative and other low-risk procedures:
This category contains any low risk procedure involving light (anxiolysis) or no sedation where protective reflexes are expected to remain unchanged, no amnesia experienced, and pain or anxiety is reduced.

Procedures such as, but not limited to, the following are included in this category: Diagnostic imaging without IV sedation, lumbar punctures, amniocentesis, arthrography, sinograms, voiding cystourethrogram, myelograms, paracentesis, thoracentesis, PICC placement, injections, gastrostomy tube and non-implanted IV access device removal, esophageal manometry, pH monitoring, pill cams, and ophthalmologic laser procedures without sedation.

Non-operative and other low-risk procedures do not require a complete H&P, but at a minimum, require a procedural note. A radiology imaging report or result in the chart suffices for example.

Discharge Summary Requirements:

A) For continuity of care, the goal is to have the discharge summary completed within four days following the patient's discharge. A discharge summary is required on all inpatient and observation accounts whose stay is equal to or more than 48 hours. A discharge summary is required on all mother's medical records whose infants have an Apgar score of 5 or below at 5 minutes. A discharge summary is required on all mothers' that deliver by c-section. A discharge summary should be completed within 30 days of discharge. Please refer to exceptions below.
   a. If the stay is less than 48 hours and no procedures were performed, a short stay summary will meet requirements. Please refer to Short Stay Note Requirements.
   b. Patients leaving the hospital against medical advice; the attending physician should indicate in the discharge summary, but a discharge order need not be written.

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B) Responsibility of the Discharge Summary: See table Addendum A for co-signature requirements

1. Discharging physician – should be completed by the discharging physician or the attending
2. Nurse Practitioner –
3. Physician Assistant -

C) Content of the Discharge Summary
1. Provisional diagnosis or reason for admission
2. Principal and secondary diagnoses
3. Clinical resume
4. Significant findings
5. Procedures performed
6. Treatment rendered
7. Condition of patient at discharge; in the cases of death, the date and preliminary cause of death
8. Specific instructions given to patient and/or family, including provisions for follow up care

Emergency Department Notes:

Emergency Department Notes should be completed within 48 hours of the visit.

Short Stay Note Requirements:

A) For continuity of care, the goal is to have the short stay note completed within four days following the patient's discharge. A short stay note shall be required on all inpatient and observation accounts whose stay was less than 48 hours except as in the specific cases as noted above in Discharge Summary Requirements. A short stay note should be documented within 30 days of discharge.

B) Responsibility of the Short Stay Note See table Addendum A for co-signature requirements
1. Discharging physician – if the short stay note is not dictated immediately following discharge and another physician is responsible for the short stay note, the discharging physician must indicate through an order or progress note whom is responsible for the short stay note.
2. Nurse Practitioner -
3. Physician Assistant -

C) Content of the Short Stay Note
1. Reason for admission
2. Condition at discharge
3. Disposition of patient
4. Discharge instructions, including follow-up care

Operative Note Requirements:

A) If a detailed operative note is not documented electronically immediately following surgery, a brief operative note/post-operative progress note must be documented in the chart following surgery. A detailed operative or other high risk procedure report must be documented or dictated within 24 hours following surgery.

B) When documenting the brief operative note/post-operative progress note or the operative note electronically within the electronic medical record, the provider must use the network template

containing all of the required elements or if the provider uses a personal template it must contain all of the required elements of the network template at a minimum.

C) Responsibility of the Brief Operative Note/Post-operative Progress Note and Operative Note
   1. Primary Surgeon
   2. Additional Surgeon- in the event that a procedure requires another surgeon, the secondary surgeon must follow same content guidelines that are pertinent to his/her role in the surgery.

D) Content of the brief operative note/post-operative progress note and operative note
   1. Brief operative note/post-operative progress note
   2. Name of Primary surgeon and assistants
   3. Procedure performed
   4. Description of findings
   5. Estimated blood loss
   6. Specimens removed
   7. Postoperative diagnosis/es
   8. Any other pertinent data, including but not limited to, complications

Operative Note
   1. Name of primary surgeon and any co-surgeon
   2. Name of procedure
   3. Description of procedure, techniques, and/or methods
   4. Findings of procedure
   5. Estimated blood loss
   6. Specimens removed
   7. Post-operative diagnosis/es
   8. Any other pertinent data, including but not limited to, complications

Labor and Delivery Note:

A) A Labor and Delivery Note is required for all newborn and vaginal deliveries. In instances where an infant is admitted to NICU, the note shall be documented prior to the transfer. In all other instances, the note is due within 24 hours of the delivery.
B) Responsibility of the Labor and Delivery Note- Delivering Physician
C) Content of the Labor and Delivery Note- Complete account of the labor and delivery

Consultations:

A) Consultation documentation is required in all cases where a consultation has been ordered and completed by the consulting provider. A consultation includes review of the medical record and examination of the patient. Surgical consultation documentation is recorded prior to surgery. Consultations must be documented within 24 hours from evaluation of the patient.
B) Responsibility of the Consultation- Consulting provider
C) Content of the Consultation
   1. Pertinent findings
   2. Opinions of the consultant

3. Recommendations of the consultant

Authentication of Records:

A) All entries in the medical record should include signature, time and date. The authentication is a reflection that the entry is complete, accurate and final. Authentication can be verified through electronic signatures or written signatures. All signatures must be completed within 30 days of discharge.
B) Responsibility of the Authentication- only individuals who are authorized to make entries in the medical record (outlined in CORP.#: CLN-2039).
C) Content
   1. Signature – minimum of first initial, last name and credential
   2. Time
   3. Date
D) Electronic signatures are acceptable in the medical record when the signature is linked to a unique identifier, biometric, password, or other secure key/method issued solely for use by the individual performing the authentication.
E) Signature stamps cannot be used in the medical record (approved 8/11/2008).
F) All orders, including per protocol and read back and verify verbal and telephone orders need to be co-signed within 30 days of discharge.

Pre Anesthesia Documentation:

A) A pre-anesthesia evaluation must be performed for each patient who receives general, regional or monitored anesthesia prior to the start of anesthesia.
B) Responsibility of the Pre- Anesthesia Evaluation:
   1. A qualified anesthesiologist;
   2. A doctor of medicine or osteopathy (other than an anesthesiologist);
   3. A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
   4. A certified registered nurse anesthetist (CRNA)
   5. An anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed.
C) Content
   Within same day as anesthesia
   1. Review of the medical history, including anesthesia, drug and allergy history; and
   2. Interview, if possible given the patient's condition, and examination of the patient
   within 30 days prior to anesthesia
   1. Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk);
   2. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

3. Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);
4. Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.

Post Anesthesia Documentation:

A) A post anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services or prior to discharge. The evaluation is required any time general, regional, or monitored anesthesia has been administered to the patient. The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area.

B) Responsibility of the Post-Anesthesia Evaluation:
   1. A qualified anesthesiologist;
   2. A doctor of medicine or osteopathy (other than an anesthesiologist);
   3. A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
   4. A certified registered nurse anesthetist (CRNA); or
   5. An anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed.

C) Content
   a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
   b. Cardiovascular function, including pulse rate and blood pressure;
   c. Mental status;
   d. Temperature;
   e. Pain;
   f. Nausea and vomiting; and
   g. Postoperative hydration.

   Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

Dental Records/Oral Surgery Records:

A) The medical record should include a description of the oral cavity as well as a detailed description of the problem by the attending dentist/oral surgeon.

B) The history and physical may be provided by the oral surgeon/dentist if he/she has privileges to perform otherwise must be provided by a physician member of the Medical Staff.

Podiatry Records:

A) The history and physical must be provided by a physician member of the Medical Staff. The podiatrist should perform the part of the history and physical pertaining to podiatry.

Progress Notes:

A) OB/GYN daily progress notes required on post-surgical/delivery patients

B) Daily progress notes required for patients in critical care, ICU, and CCU.

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C) Hospice patients must have progress notes documented on a weekly basis.
D) All other patients must have progress notes documented and signed every 48 hours with the following content:
   a. Changes in patient condition
   b. Changes in treatment or medication
   c. Progress from therapies
   d. Results from treatment
   e. Discharge planning as applicable

Outpatient Orders:

A) Outpatient orders for testing and treatment signed and ordered by Residents, Physician Assistants, and Nurse Practitioners are valid orders with no co-signature required by a physician unless the Resident, PA or NP specifies and requests a physician co-signature. Emergency Room excluded.

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Addendum A: Medical Record Documentation Rules/Co-signature Requirements

Hospital Inpatient, Observation, Outpatient in a Bed, Outpatient Surgery, Inpatient Behavioral Health
YES means they can document/perform, NO means they cannot document/perform)

Documentation	Medical Staff Member (MSM)	Resident/ Fellows in Training	Advance Practice Provider Advance Practice Nurse (NP, CNM, CNS) Physician Assistant Neuropsychologist	Dependent Allied Health Practitioner (RN, LPN, CST, etc.)
H & P	Yes	Co-signed by MSM	Co-signed by MSM, if for surgery-must be co-signed prior to surgery	No
Admission Order	Yes	Co-signed by MSM	No	No
Discharge Summary (includes Death Summary)	Yes	Co-signed by MSM	Co-signed by MSM	Co-signed by MSM
Consultations	Yes	Co-signed by MSM	May document and sign own consultation If MSM consultation requested, MSM must respond and document the consult or edit and sign the APP consult	No
Operative Note	Yes	Co-signed by MSM	Immediate post-operative note/brief operative note may be documented by the APP, but must be immediately signed by the surgeon. The operative report must be entered by the surgeon.	No
Anesthesia Record	Yes	Co-signed by MSM		No
Clinical Reports	Yes	Co-signed by MSM	No	No
Progress Notes	Yes	Yes co-signature not required	May document and sign own progress note, however if MSM plans to use	May document and sign own progress note, however if MSM plans to use

			the progress note as evidence of daily visit, MSM must sign and date	the progress note as evidence of daily visit, MSM must sign and date
Telephone and Verbal Orders (limited use)	Yes	Yes Co-signature required	Yes Co-signature not required	Yes Co-signature required
Orders	Yes	Yes Co-signature required	May write own orders Co-signature not required	No
Restraint Orders	Yes	Must by co-signed by MSM ASAP	Must be obtained by a Licensed Independent Practitioner	Must be obtained by a Licensed Independent Practitioner
Informed Consent	Yes	Co-signed by MSM	Yes Must be obtained by a Licensed Independent Practitioner	Yes Must be obtained by a Licensed Independent Practitioner
Emergency Department Records	Yes	Yes Co-signed by MSM	Yes Co-signed by MSM	No
Psychiatric Evaluation	Yes	Yes Co-signed by MSM	Yes Co-signed by MSM	No

Voice Recognition Technology:

Disclaimers regarding the use of voice recognition technology/software should NOT be included in documentation in the medical record. For example, this encounter note was prepared using voice-recognition software. Please disregard any "typos" or unintentional errors in transcription that may have occurred.

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