



Subject: MEDICAL RECORDS DOCUMENTATION

Originator: Health Information Management (HIM)

Approval Date: April 9, 2014

Approved By: _____
Mark T. Steele, M.D., Chief Medical Officer

Policy:

It is the policy of Truman Medical Centers (TMC) to create and maintain medical records in the regular course of its business of delivering patient care. As such the medical record must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards and legal standards.

Purpose:

The intent of this policy is to specify the manner in which medical records should be maintained.

Scope: Corporate-wide

Definitions:

Cloning: Creating an exact copy which is usually appropriate within the context of the EHR. The act of using prior notes in constructing new progress notes has been described as “cloning notes”.

Copy & Paste: Selecting data from an original or previous source to reproduce in another location.

Data Linking: Using shortcuts to insert data from another part of a patient record into a progress note.

Copy Forward: A function that copies a significant section or entire prior note.

Procedure:

Authorized Users – persons who may document in the medical record include the following:

- Staff directly involved in the care of the patient such as but not limited to:

- Practitioners, Residents, Certified Nurse Midwives, Physician Assistants, Nurse Practitioners and other individuals who have been granted clinical privileges;
- Nursing health care providers including Registered Nurse, LPNs, Patient Care Technicians, Medical Assistants, CNAs, and others responsible to the nurse manager or physicians;
- Professionals responding to a request for consultation when the professional has clinical privileges or is an employee (or Resident) or a member of a Medical Staff Committee (e.g., Ethics Committee);
- Other health care professionals involved in patient care, but not limited to physical therapists, occupational therapists, respiratory therapists, pharmacists, licensed dietitians, social workers, case managers, radiology technicians, respiratory therapists and chaplains;
- Volunteers such as volunteer chaplains functioning within their approved roles;
- Students in an approved professional education program who are involved in patient care as a part of their education process may document in the medical record if that documentation is reviewed and countersigned by the student's supervisor who must also be an authorized user;
- Support or non-clinical staff such as, but not limited to, Interpreters may make entries in the medical record to document administrative issues.
- Other staff as appropriate or defined in their job duties.

Chronology of Entries:

- It is strongly recommended that all materials in the medical record be organized in a chronological and systematic manner.
- The record must reflect the continuous chronology of the patient's healthcare. The universal chart order shall be used for inpatient and ambulatory medical records.
- Clinical documentation should be documented during or immediately after care has occurred.

Timing and Dating of Entries:

- All entries must be timed and dated.
- It is recommended that entries be recorded as closely as possible to the time of the encounter. This will allow for more detailed, accurate and comprehensive medical records.
- It is recommended that all paper-based entries in the medical record be in black or blue ink to facilitate legible reproduction of records. Entries should not be made in pencil.

Authentication of Medical Record Entries:

- Initials can only be used on medical record forms approved by the organization, such as flow sheets, medication records or treatment records. They should not be used for such entries as narrative notes or assessments. Initials should never be used for entries where a signature is required by law.

Legibility and Clarity:

- Regulations require that medical records be legible. Legible shall be defined as a notation that can be clearly or easily read.
- TMC expects that the medical record can be interpreted by the average health care professional.
- Do not use text message language in documentation
- Do not use unapproved abbreviations (See TMC Unapproved Abbreviations List on the E-care page).

Error Correction Process:

- At no time is it permissible to obliterate or remove a previous entry in the medical record (paper or electronic).
- When an error is made in a paper-based medical record entry, the following error correction procedures must be followed:
 - Draw a line through the entry. Make sure the inaccurate information is still legible. Do not write error on the line.
 - Sign and date the entry.
 - Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line, document the current date and time and referring back to the incorrect entry.
 - Do Not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout or writing over an entry.
 - Do Not write over words or numbers. If an error is made follow the procedure above.
- When an error is made in an electronic medical record entry, the following error correction must be followed:
 - An “Addendum” note should be dictated or typed referencing the incorrect documentation or dictation number.
 - When correcting or making a change to an entry in the computerized medical record/electronic health record (EHR), the original should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted.

Late Entries:

- When a pertinent entry was missed or not written in a timely manner, a later entry should be used to record the information in the medical record:
 - Identify the new entry as “late entry.”
 - Enter the current date and time. Do not try to give the appearance that the entry was made on a previous date or time.
 - Identify or refer to the date and incident for which the late entry is written.
 - If the late entry is used to document an omission, validate the source of additional information as much as possible (i.e., where you obtained the information to write the late entry).

- When using late entries, document as soon as possible. There is no limit to writing a late entry, however, keep in mind that the more time passes, the less reliable the entry becomes.

Use of Abbreviations and Symbols:

- For the clarity of documentation, symbols and abbreviations are discouraged.
- If abbreviations and symbols are used in the medical record they must be those that are on the TMC Approved abbreviation/symbol list.
 - [See](#) Approved Abbreviation list on the HIM intranet site.
- Do not use abbreviations on the Unapproved Abbreviation List.
 - [See](#) the Unapproved Abbreviation list on the HIM intranet site.

System Downtime:

- Refer to department downtime policies.

Security and Protection of Medical Records:

- See “Confidentiality Policy and Procedure”.

Removing Medical Records from the HIM department or Hospital Premises:

- Hospital records are the property of TMC and removal from hospital premises is prohibited.
- If a subpoena or court order is received requesting removal, contact the Health Information Manager of Operations.
- It is requested that records NOT be removed from the HIM department, except records needed for direct patient care. Records must be available and accessible when needed for patient care.

Documentation Principles – see attachment A:

- Regardless of the format, text entries, canned phrases, or templates should follow fundamental principles for the quality of the entry. Content should be specific, objective, and complete.
 - Use **specific** language and avoid vague or generalized language. Do not speculate. The record should always reflect factual information (what is known versus what is thought or presumed), and it should be written using factual statements. Examples of generalizations and vague words include patient doing well, appears to be confused, anxious, status quo, stable, as usual. If an author must speculate (e.g., diagnosis is undetermined), the documentation should clearly identify speculation versus factual information.
 - Chart **objective** facts and avoid using personal opinions. By documenting what can be seen, heard, touched, and smelled, entries will be specific and objective. Describe signs and symptoms, use quotation marks when quoting the patient, and document the patient’s response to care.
 - Document the **complete** facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviation from standard treatment (including the reason for it). Make sure

the entry is complete and contains all significant information. If the original entry is incomplete, follow guidelines for making a late entry, addendum, or clarification.

Medical Record Retention:

- See Hospital Record Retention policy

Medical Record Content:

- At each facility, a single, lifetime medical record number is issued for each patient and is used for inpatient hospitalizations and for outpatient visits on the main campus, at TMC.
- A medical record is maintained for every patient hospitalized, treated in the Emergency Department, Outpatient Department Clinics, and Ambulatory Surgery. Records may be maintained in hardcopy and/or electronically. Paper based medical records are filed in the HIM Department.
- See The Joint Commission guidelines for record content.
- Below are suggested elements for the following medical record reports:

Use of Cloned Documentation in the Electronic Medical Record

Previously entered data, when used in a new note, should always be meticulously updated and edited to reflect the scope of, and interval changes in, the history and physical examination findings. Therefore, a more accurate description of this process would be using a prior note as a “template” for a new note. The term template indicates a starting point for a new note that is appropriately edited to accurately reflect the current reality.

General Information/Requirements

- There can be value to copying information, but it must be done selectively and used thoughtfully with the goal of producing a clear, useful, and accurate patient note.
- Regardless of the tools used to create the note, the individual signing it acknowledges responsibility for the entire content.
- The note must accurately represent clinical work performed on the day of service, with clear attribution of the work of others.

Acceptable Use of Previously Entered Data

- Copying and pasting or copying forward of history of present illness (HPI), review of systems (ROS), pertinent family history, and pertinent social history (PFSH), Physical Examination, and Plan of Care from a previous visit note by the same author must meet these conditions:
 1. The information is reviewed with the patient and fully updated to reflect current reality.
 2. The information is medically necessary to support billing and coding for the current visit.
- Copying and pasting or copying forward HPI, ROS, and PFSH from a previous note by a different author must meet these conditions:

1. The original author, source, and date of the information are documented.
 2. The information is reviewed with the patient and fully updated to reflect current reality.
 3. The information is medically necessary to support billing and coding for the current visit.
- Data linking to insert data from another part of the patient's record into a progress note must meet these conditions:
 1. The information is reviewed and updated prior to being pulled into the current note.
 2. The date the information was updated and the person who performed the update are documented.
 3. The information is medically necessary to support billing and coding for the current visit.

Unacceptable Use of Previously Entered Data

- Copying an entire previous note without appropriate edits.
- Transferring information from one patient record to the record of another patient.
- Copying and pasting Medical Student and Physician Assistant Student notes (other than the ROS and PFSH).
- Attestation by attending.
- Plan of care from a provider with another service.

History and Physical

A History and Physical Examination (H&P) is required:

- For all hospital admissions (adequate for the duration of the hospital stay)
- For consultations requesting evaluation and/or treatment
- Before all outpatient invasive procedures, except minimally invasive procedures
- For all new patients in an outpatient setting, including all emergency department patients
- Prior to performance of moderate or deep sedation on outpatients

For inpatient H&Ps and for H&Ps performed prior to moderate or conscious sedation, the following elements are required: a chief complaint, HPI, a pertinent past medical history, PFSH, a pertinent ROS, a physical examination, an assessment of the patient's status, and a plan of treatment. The breadth and depth of each element will be dictated by the nature of the patient's problem.

For any H&P done for other than the above, at minimum, the H&P should contain a chief complaint, HPI, examination, assessment, and plan. It will be left to the practitioner's discretion whether the situation requires the additional elements (a pertinent past medical history, PFSH, a pertinent ROS) to be included.

Outpatient surgical procedures requiring only local anesthetic do not require a formal H&P. However, documentation is required no more than 30 days prior to the procedure that allergies, medications, and medical history were assessed

and that further interventions were not required to reduce the risk of the procedure.

Updated H&P

H&Ps done within 30 days prior to admission/procedure must be updated within 24 hours of admission and immediately prior to procedure. The update will document an examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment. If upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.

Operative Report

1. Dictating physician's name
2. Patient name
3. Location of procedure (inpatient/outpatient)
4. Date of procedure
5. Preoperative diagnosis
6. Postoperative diagnosis
7. Name of procedure
8. Names of surgical team member (including medical students)
9. Name of attending surgeon
10. Type of anesthesia
11. Estimated blood loss
12. Complications
13. Specimens removed (yes/no)
14. Description /findings of procedure
15. Condition of patient upon discharge to recovery area

Discharge Summary

1. Dictating physician's name
2. Date of dictation
3. Attending physician's name
4. Patient's name
5. Medical record number
6. Admission date
7. Discharge date
8. Type of admission (emergency, elective, urgent)
9. Admitting diagnosis and/or reason for admission
10. Subjective findings
11. Objective findings
12. Hospital course
13. Discharge instructions* (the following statement must be dictated):
 - a. "The patient (or family) was given the following instructions:"

- b. Activity
 - c. Medications
 - d. Diet
 - e. Follow up
14. Final diagnosis (no abbreviations):
- a. Principle diagnosis (the diagnosis determined, after study to occasion the admission of the patient)
 - b. Complication, co-morbid conditions addressed during this stay
15. Procedure performed
16. Plans (follow-up in clinic, readmit for staged procedures, etc.)

Problem List – for Outpatient records, must be established by the third visit.

- 1. Known significant medical diagnoses and conditions
- 2. Known significant operative and invasive procedures
- 3. Known adverse and allergic drug reactions
- 4. Known long-term medications, including current prescriptions, over-the-counter drugs, and herbal preparations

Reference: *Update: Maintaining a Legally Sound Health Record – Paper and Electronic.” Journal of AHIMA 76, no. 10 (November-December 2005): 64A-L.

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Reviewed Dates: (list dates in descending order)

Reviewed Date: _____ Initials: _____

Reviewed Date: _____ Initials: _____

Reviewed Date: _____ Initials: _____

Attachment A – Documentation Guidelines:

Reference: “Guidelines for Medical Record and Clinical Documentation” WHO-SEARO Coding Workshop September 2007

