MOUNT CLEMENS
REGIONAL MEDICAL CENTER
A McLAREN HEALTH SERVICE

Medical Record Completion Guidelines

Medical Record Committee Approval: August 24, 2011
Staff Executive Committee Approval: September 2011
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I. DEFINITIONS

A. "Allied Health Professional" (a.k.a Mid-Level Practitioners") – an individual, other than a licensed physician, whose patient care activities require that his authority to perform specified patient care services be processed through medical staff channels or with involvement of medical staff representatives.

B. "Attending physician" – primary physician providing care, or on teaching cases, the physician supervising the residents/medical students on the case.

C. "Author" – the physician, resident or allied health professional writing or dictating a report.

D. "Practitioner" – means, unless otherwise expressly limited, any appropriately licensed physician, podiatrist, or dentist applying for, or exercising, clinical privileges in this hospital.

II. REQUIREMENTS FOR MEDICAL RECORD DOCUMENTATION

A. A legal, accurate medical record shall be maintained for every person treated as an inpatient, outpatient, or emergency patient.

B. The medical record shall contain sufficient information to identify the patient clearly, to support the diagnosis and justify the treatment, and to document the results accurately and in a timely manner. All entries shall be accurately dated and timed by the author. The medical record shall also contain evidence of appropriate informed consent for any procedure or treatment for which it is appropriate.

1. All caregivers providing service to the patient are authorized to document in the medical record on specific forms for their area or in the progress notes, including pastoral care.

C. Medical Records shall be confidential, current, accurate, legible, complete and secure.

D. The attending Practitioner shall be responsible for the preparation of a complete, current, accurate, pertinent, and legible permanent medical record for each of his patients.

<u>This medical record shall contain:</u>

1. Identification data;
2. Medical history;
3. Physical examination;
4. Diagnostic and therapeutic orders;
5. Evidence of appropriate informed consent;

6. Clinical observations, including results of therapy;
7. Reports of procedures, operations, tests, and results thereof;
8. Consultation reports when applicable;
9. Autopsy report when appropriate;
10. Detailed discharge instructions; and
11. A discharge summary at termination of hospitalization to include principal diagnoses, secondary diagnoses if appropriate, and prognostics.

E. The hospital medical record shall include at least the following:

1. **Face Sheet**
Demographic information is entered at time of patient admission as follows, if available:

a. Patient name, social security number, address, phone number, sex, race, age, birth

b. Date, marital status, religion, church.

c. Next of kin, address, phone number, relationship.

d. Emergency contact, address, phone number, relationship.

e. Patient employer, occupation.

f. Responsible party, relationship, employer, address, phone number, social security number.

g. Insurance information.

2. **Coding Summary**

The coding summary shall include:

a. All pertinent diagnoses, including complications, which can be coded using ICD-9-CM.

b. All operative procedures, including invasive diagnostic procedures which can be coded using ICD-9-CM and/or CPT-4 in accordance with coding guidelines.

3. **Emergency Room Report**

a. All reports shall be completed within a timely manner.

It is recommended the Emergency Room Report be completed immediately following the conclusion of treatment.

b. Note the following when completing Emergency Room Records:

i). Clinical appropriateness

ii). Standard of care to support patient visit to ER

- History: including how, when and where an injury occurred or when symptoms first appeared.

- Physical Findings*:* including the site and approximate extent of lacerations; site, and degree and percent of body surface of burns.

- Management: treatment given including anesthetic used, if any, and number and type of sutures, injections, shots, dressing or cast application.

- Diagnostic Test Ordered*:* include the specific diagnostic (x-ray/lab/cardio) test ordered and results.

- Diagnosis*:* including specific detailed diagnosis, state medical condition or site, including right, left or bilateral; state type of trauma or injury, such as abrasion, contusion, concussion, lacerations, etc.

c. When a patient is pronounced or DOA in the Emergency Room, the physical findings which established the diagnosis should be included in the record.

4. **History and Physical Examination**

H &P must be completed within 24 hours after admission either in written or dictated form. A History and Physical Examination Report must be completed prior to the initiation of any surgical or other invasive procedure. No patient shall be taken to the operating or procedure room unless a History and Physical (appropriate for the procedure being performed) and a preoperative diagnosis have been written or dictated and are available on the medical record at the onset of the procedure.

All H&P's require completion of the Osteopathic Musculoskeletal Examination. If the H&P is dictated, the physician completing the H&P must complete the Osteopathic Musculoskeletal Examination paper form and place in the patient's medical record.

The required History and Physical may be completed up to 30 days prior to an admission and/or procedure, but an updated examination is required within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia service. A History and Physical Examination performed up to 30 days prior to the admission will be accepted if the following are included in an addendum on the H&P or in the progress notes:

-pertinent additions to the history;
-subsequent changes to the physical findings;
-statement the History and Physical form was reviewed, signed and dated.

Failure to complete the History and Physical may result in cancellation of the procedure unless the physician states in writing that such a delay would be detrimental to the patient. If such is stated, the History and Physical is to be

completed within 24 hours of the emergency procedure as documented by the physician. (*These provisions may be waived in extreme emergency, but a preoperative diagnosis shall be recorded in the medical record and the History and Physical completed within 24 hours post-procedure.).*

a. Required for:
   i). All inpatient admissions
   ii). All surgery, including outpatient
   iii). Any procedure requiring anesthesia other than minimal anesthesia (local anesthesia)
   iv). Observation admissions

b. Authentication (signature)
   The document must be signed AND dated by the author or if written/dictated by a resident must also be signed by the attending/supervising physician.

c. Content

   i). Patient Identification/Date of Admission

   ii). History
   - Chief Complaint
   - History of Present Illness
   - Past History: including previous operations, illnesses and injuries
   - Allergies
   - Present Medications
   - Family History
   - Social/Occupational History
   - Pediatric/Adolescent patients: if not documented elsewhere
     - ➢ Immunization Status
     - ➢ Evaluation of patient's developmental age
       - Considerations of education needs and daily activities
       - Family/guardian's expectations for involvement in the assessment, treatment and continued care.

d. Review of Systems

   A statement of any positive complaints or "no abnormalities" is required.
   i). General
   ii). Eyes
   iii). ENT
   iv). Respiratory
   v). Cardiovascular
   vi). Integumentary
   vii). Gastrointestinal
   viii). Genitourinary
   ix). Musculoskeletal
   x). Neurological

   In addition, the following review of systems may be included:

xi). Endocrine
xii). Lymphatic/Hematologic
xiii). Immunological/Allergic
xiv). Psychological

e. Physical Examination

i). General and Skin
ii). Head and EENT
iii). Lymph Nodes
iv). Heart and Lung
v). Chest/Breast
vi). Abdomen
vii). Genitalia
viii). Pelvic:
- Required on all female patients with mention of gynecological condition.
- Results of pelvic exam performed in the office within the last 7 days are acceptable in lieu of a pelvic exam on admission.
- All cases admitted for pelvic surgery required documentation relative to a Papanicolaou smear within 12 months prior to admission.

ix). Rectal (required for all patients with a rectal problem)
x). Musculoskeletal
xi). Neurological
xii). Mental Status
xiii). Oral Findings (required for all patients having oral surgery, can also be documented in consultation or progress note)
xiv). An osteopathic musculoskeletal examination is required as an integral part of the History & Physical performed by osteopathic physicians on their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this examination is contraindicated.

xv). Diagnostic Findings

xvi). Impression

xvii). Treatment Plan

f. Office History & Physical

The required History and Physical may have been completed up to 30 days prior to the procedure, but any significant changes in the condition of the patient must be recorded immediately prior to performance of the procedure or at the time of admission. (See above requirements.)

5. **Readmission Note**

An interval Readmission Note may be recorded as the History and Physical, if a complete history and physical has been recorded and a physical examination performed within 30 days prior to the patient's current admission to the hospital for the same or related condition.

a. Readmission Note shall include:

i). pertinent additions to the history;
ii). subsequent changes in physical findings;
iii). statement patient was re-examined and chart reviewed; and

6. **Admit Note**

Contains a statement with sufficient history and positive physical findings to warrant acute hospital admission

a. The admit note may be used as the History and Physical if the History and Physical contents are present.

b. An admitting note is required at the time of the acute hospital admission, unless the History and Physical is handwritten or dictated.

While a complete H&P by the attending physician is preferred, if all elements of the H&P are documented elsewhere in the record in a single source, indications that the record is being used for an H&P and that the attending is in agreement must be included in the admit note for the previous documentation to be considered an H&P.

7. **Consultations**

Only one Active/ Active-Affiliate Staff member may be designated as admitting (attending) physician responsible for patient care until the patient is transferred or discharged. The attending physician is responsible for requesting a consultation, and there should be documentation of the indication for the consult.

The following categories are recommended:

a. <u>Consultation Only</u> which leaves the management to the attending physician and prohibits consultants from writing orders on the chart.

b. <u>Consultation and Participation</u> of a specific entity or procedure in which the consultant may write orders to manage the special entity or procedure but overall responsibility remains with the attending physician.

c. <u>Management is transferred</u> to another named physician in which case patient care responsibilities in the hospital are transferred to the named physician, and the admitting physician may no longer write orders.

If the attending physician and the consultant disagree on management of a patient, a second consultation shall be ordered.

MANDATORY CONSULTATIONS: Consultations are required on critically ill patients, patients who are poor surgical risks, and those whose diagnoses are difficult or obscure, except in emergencies. Specific mandatory consultations may be identified by the specific specialty services.

TIME FRAME: Consultations shall be performed in a timely fashion (24 hours). Consultations within Critical Care services (ICU) should be performed within twelve (12) hours by an intensivist.

8. **Record of Operation and Reports of Other Invasive Procedures**

a. Required for:

i). An operative/procedure report is required for operative or other procedures involving anesthesia or conscious sedation.

b. Reports of operative and invasive procedures must be written or dictated within twenty four hours of performing the procedure.

c. A post-operative progress note about the procedure(s) is entered immediately in the medical record to briefly describe the pre-operative and post-operative diagnosis, procedure(s) performed, findings, specimens removed, complication, if any, estimated blood loss, and name of surgeon(s)/assistant(s).

Authentication (signature)

The document must be signed AND dated by the author, or if written/dictated by a resident must also be signed by the attending/supervising physician.

9. **Progress Notes**

a. Frequency

i). Daily progress notes shall be documented for all patients as

ii). Evidence that the patient is under the care of a physician in an acute care setting.

b. Content

i). Pertinent chronological documentation of the patient's course in the hospital showing change in the patient's condition and the results of treatment.

ii). A statement of the patient status, whether improved, unchanged, regressing, etc.

iii). Any pertinent x-ray or laboratory data, physical findings or addendum to history of present illness.

c. Current assessment

i). Be legible, dated/timed/signed by author

ii). To document an omitted note the caregiver should date the note as written and indicate that his/her observations reflect the condition of the patient on the previous date.

10. **Orders**

The terms “verbal” orders and “telephoned” orders are not interchangeable.

The use of verbal orders should be limited to those situations in which it is impossible or impractical for the ordering practitioner to write a manual or electronic order.

Verbal orders may be taken from licensed physicians (DO, MD), Podiatrists (DPM), independent Allied Health Professionals (AHPs) (i.e.DDS and Oral Surgeons), and by qualified employees of MCRMC.

Qualified employees or dependent AHPs include but are not limited to:

a. Licensed professionals (i.e. RN, RPh, PT, PA, CRNA, NP)
b. Certified or registered health care providers (RT, OT, ST, RD)

Verbal orders must be reviewed, countersigned, dated and timed by the physician responsible for those orders within 48 hours. Facsimile (rubber stamp) authentication is prohibited for drug orders.

Verbal orders are prohibited for chemotherapy.

Entire verbal order should be repeated back to the prescriber.

Telephoned orders (a type of verbal order) refer to those situations in which the ordering practitioner is not physically present when providing patient care orders. With telephoned orders, the practitioner may be in another location within the facility or outside the facility. All requirements for verbal orders, as stated above, also apply to telephoned orders

11. **Discharge Summary**

A dictated Discharge Summary is required for:

a. Patients who stay greater than two (2) calendar days
b. Expirations
c. Complicated Deliveries
d. Newborn with Complications
e. Transfers
f. Cesarean Section Deliveries
g. Observation stays greater than two (2) days (48 hours)

Authentication (signature)

The document must be signed AND dated by the author or if written/dictated by a resident, or other allied health professional must also be signed by the attending/supervising physician.

Contents shall include:

a. Resolution of the admission diagnosis, chief complaint & final diagnosis.
b. Course of the facility stay
c. Interventions, procedures, operations, consultations, etc
d. Any complications arising and how they were managed
e. Progress made in regard to specific interventions (i.e., physical therapy, respiratory care, etc.)
f. Difficulties in establishing the diagnosis and effective treatment plan.
g. Condition at Discharge
h. Instructions for follow-care including nutrition, medication, activity, referrals & next appointment if appropriate with the attending.
i. Instructions for pain management post discharge.

A concise discharge summary must be completed (dicated and signed) on each patient within 7 days of patient discharge. For newborns with uncomplicated deliveries, or for patients hospitalized for two (2) calendar days or less, a progress note may be substituted for the discharge summary. The progress note, which may be handwritten, documents the patient's condition at discharge, discharge instructions, and required follow-up care.

12. **Use of Symbols/Abbreviations in Medical Record**

The use of symbols/abbreviations related to patient care, treatment, or orders is discouraged except those approved abbreviations designated by the Staff Executive Committee as reflected in the "Standard Medical Reference for Approved Abbreviations: Stedman's Abbreviations, Acronyms & Symbols."

Prohibited Abbreviations

Do Not Abbreviate	Intended Meaning	Misinterpretation	Write
U IU	Units International Units	Mistaken as "0" (e.g. Insulin 1U per hour mistaken for 10 per hour	Spell out the word "unit"
Q.D. or qd Q.O.D. or qod	Every day Every other day	These can be mistaken for each other. The period placed between letters or sloppy letters can lend to misinterpretation.	Use "daily" or "every other day"
Trailing zero (X.0 mg) Lack of a leading zero (.X mg)		Decimal point is missed.	Never write a zero by itself after a decimal point ((X mg), and always use a zero before a decimal point (0.X mg). May result in a 10-fold dose error.
MS MSO_4 $MgSO_4$	Morphine Morphine sulfate Magnesium sulfate	Confused for one another. Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"

III. SUSPENSION PROCESS

All medical records shall be completed within thirty (30) calendar days of patient discharge, with the exception of the discharge summary which shall be completed within seven (7) days. Any records not completed by the thirty-first (31st) day after patient discharge are considered "Delinquent". Any discharge summary not completed by the eighth (8^{th}) day shall be considered delinquent.

The practitioner who fails to complete his discharge summary within seven (7) calendar days of patient discharge and all other documentation within thirty (30) calendar days shall automatically be suspended. Suspension shall include admitting privileges, consulting privileges and surgical/procedure boarding.

In cases where a Resident Physician or Allied Health professional is involved in the care and documentation within the patient's medical record, the Attending Physician is ultimately responsible for completion of that medical record.

It is the responsibility of the Physician and Resident Physician to check the aging status of his records by accessing the Electronic Medical Records System. Each deficiency's aging status is indicated by one of the following categories: Pending Suspension (Red), Delinquency (Yellow), Warning (Tan) or Incomplete (Blue). It is the responsibility of the Physician and Resident Physician to complete his records before they age to a suspension status (31 days or greater).

A. Health Information Services shall send weekly fax notification for medical record deficiencies greater than 30 days, or 8 days for discharge summaries, to Physicians and Resident Physicians notifying of suspension. The notice will provide information to assist the physician in accessing PIE to complete deficiencies. Please see ATTACHMENT B.

B. A physician will be expected to complete all assigned deficiencies prior to the anticipated absence. Records that age greater than thirty (30) days during this absence will be considered delinquent.

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Medical Record Committee Action for filing incomplete medical records

If 120 days following a patient's discharge, the Attending Physician is or has become incapacitated, ill, deceased, resigned, been removed from the Professional staff, or have moved from the community, the Director of the Health Information Services department and/or a designee, shall recommend to the Medical Record Committee that appropriate action be taken to file the medical record incomplete.

Delinquent Records, Physician 30-Day Suspension Letter

ATTACHMENT B

Date

Dear Dr. _____:

As defined in the Bylaws, you will be suspended until your medical records are completed. Inasmuch as your medical records remain incomplete, *you may not admit, board, perform procedures, accept referrals or consultations.* At this point in time, the only clinical activity you are permitted is to care for any patients who are currently hospitalized.

Please log in to PIE to complete your charts https://pie.mclaren.org/mcrmcpie

Sincerely,

Michael K. Smith, D.O.
VP, Medical Affairs & Chief Medical Officer
Mount Clemens Regional Medical Center