

## McLaren Macomb

### Medical Record Completion Standards

#### I. PURPOSE

- A. To establish standards for the contents and maintenance of patient Medical Records that meet the requirements set forth in accreditation standards and Federal and State laws and regulations. To define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record. This defines requirements for those components of information that comprise a patient's complete "Legal Medical Record."

#### II. DEFINITIONS

- A. **Allied Health Professional** - a.k.a. Mid-Level Practitioner (MLP) or Advance Practice Professional (APP) – Licensed or certified health care professional, other than a physician, who has been approved to render patient care in the hospital (e.g., psychologist, physician assistant, nurse practitioner, etc.).
- 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, medical student 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.
- E. **Legible** – can be read without consultation with others.
- F. **Authenticate** - means signing, dating and timing by the author or his/her partner.
- G. **Electronic Health Record (EHR)** –A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR can generate a complete record of a clinical patient encounter- as well as supporting other care-related activities directly or indirectly via interface including evidence-based decision support, quality management, and outcomes reporting.
- H. **Documented** – The act of hand-entering, typing or dictating the required elements of clinical documentation (i.e., discharge summary, operative report, history and physical).
- I. **Verbal order** - Requests for patient services from a healthcare practitioner, within the practitioner's scope of practice, directly spoken to another healthcare practitioner whose scope of practice includes authorization to receive and document such orders.
- J. **Telephone order** - Requests for patient services from a healthcare practitioner, in which the ordering practitioner is not physically present, within the practitioner's scope of practice, given audibly over the telephone or other telecommunication device, to another healthcare practitioner whose scope of practice includes authorization to receive and document such orders.

### III. REQUIREMENTS FOR MEDICAL RECORD DOCUMENTATION

- A. A legal, accurate medical record shall be maintained for every person treated as an inpatient, outpatient, observation 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 authenticated (dated, timed and signed) 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. Signature Requirements:
  - 1. Legible full signature;
  - 2. Legible first initial and last name;
  - 3. Illegible signature or initials over a typed or printed name;
  - 4. Illegible signature or initials matching a signature log maintained on file by Health Information Management;
  - 5. An electronic signature.
- E. Rubber stamp signatures are not permitted, with the following exception: use of a rubber stamp is permitted for signature in the case of an author with a physical disability that can provide proof of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.
- F. The medical record and its components shall be completed, documented and all entries authenticated within time frames designated in the Medical Records Completion Oversight Policy (01-132).
- G. The medical record must contain documentation of complications, hospital acquired infections and unfavorable reactions to drugs and anesthesia.
- H. 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.
- I. The medical record shall contain:
  - 1. Identification data
  - 2. Medical History
  - 3. Physical Examination
  - 4. Admitting Diagnosis

5. Final Diagnosis
6. Advance Directive
7. Diagnostic and therapeutic orders
8. Evidence of appropriate informed consent
9. Clinical observations, including results of therapy
10. Reports of procedures, operations, tests, and results thereof
11. Consultation report, when applicable
12. Autopsy report, when appropriate
13. Detailed discharge instructions
14. Discharge Summary at termination of hospitalization

#### **IV. REQUIRED ELEMENTS OF A MEDICAL RECORD**

##### **A. FaceSheet**

- i. Demographic information, if available, is entered at the time of patient admission/registration as follows:
  - a. Patient name, their address and phone number
  - b. Sex, race and primary language.
  - c. Age, date of birth, marital status and religion
  - d. Next of kin, their address, phone number and relationship
  - e. Emergency contact, their address, phone number and relationship
  - f. Patient employer and occupation
  - g. Responsible party, their relationship, employer, address and phone number
  - h. Insurance information

##### **B. Coding Summary**

1. The coding summary shall include:
  - a. All pertinent diagnoses, including complications, which can be coded using ICD-10.
  - b. All operative procedures, including invasive diagnostic procedures which can be coded using ICD-10 and/or CPT-4 in accordance with coding guidelines.

## **C. Emergency Room Records**

1. Must contain:
  - a. Clinical appropriateness
  - b. Standard of care to support patient visit to ER
  - c. History: including how, when and where an injury occurred or when symptoms first appeared.
  - d. Physical Findings: including the site and approximate extent of lacerations; site, and degree and percent of body surface of burns.
  - e. Management: treatment given including anesthetic used, if any, and number and type of sutures, injections, shots, dressing or cast application.
  - f. Diagnostic Test Ordered: include the specific diagnostic (x-ray/lab/cardio) test ordered and results.
  - g. 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.
  - h. When a patient is pronounced deceased or DOA in the Emergency Room, the physical findings which established the diagnosis should be included in the record.

## **D. History & Physical (H&P)**

1. History and Physicals are required for the following:
  - a. All inpatient admissions
  - b. All surgery cases, including outpatient
  - c. Any procedures requiring anesthesia other than local anesthesia
  - d. All observation admissions
2. The H&P must be documented and authenticated by an individual credentialed by the medical center to perform and complete this document. If documented by an individual other than the attending physician, the attending physician must review and update the document to reflect changes or no changes and authenticate.
3. Failure to document a History and Physical may result in cancellation of a 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 documented within 24 hours of completion of the emergency procedure.

4. Minimum documentation for Inpatient H&P:
  - a. Chief complaint
  - b. Relevant History to include History of Present Illness, Past Medical, Surgical, Social and Family Histories
  - c. Medications
  - d. Allergy
  - e. Review of Systems
  - f. Pertinent physical examination to include vital signs
  - g. Cardiac examination
  - h. Pulmonary examination
5. Minimum documentation for Outpatient H&P:
  - a. Relevant medical history
  - b. Medications
  - c. Allergy
  - d. Pertinent physical examination to include vital signs
  - e. Cardiac examination
  - f. Pulmonary examination
6. Use of prior History and Physical:
  - a. 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:
    - i. Pertinent additions to the history;
    - ii. Subsequent changes to the physical findings;
    - iii. Statement the History and Physical form was reviewed, signed, timed and dated.
  - b. An update must be documented in the medical record within 24 hours after admission.
  - c. The update must be documented in all cases involving surgery or a procedure requiring anesthesia services, prior to the surgery or procedure.
  - d. When the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she must document 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.

7. ER Report as History & Physical - an ER Report may be considered as the History & Physical for ED Observation stays.
8. When a patient is pronounced deceased or leaves the hospital prior to a face to face encounter with the Attending Physician, the Attending Physician will be responsible for completing the H&P and documenting that they were unable to complete the minimum elements of the H&P.
9. Newborn Admission/Discharge Summary Form
  - a. This form may be considered an H&P for newborns.

## E. Consultations

1. The Attending Physician is responsible for requesting a consultation, and there should be documentation of the indication for the consult.

### 2. Consultation Types and Time Frame

#### a. Routine Consults

- i. Completed within a twenty-four (24) hour period from the time the consultation request is communicated to the consulting physician/designee.

#### b. Emergent Consults

- i. Completed within a four (4) hour period from the time of the request.
- ii. The physician requesting the Emergent Consult MUST personally contact the consulting physician to confirm the requesting Consultant's ability to respond within four (4) hours. If the Consultant is unable, the requesting physician shall find an alternate Consultant to respond within four (4) hours. Written documentation of the Physician-to Physician(s) communication must be present (timed, dated and signed) in the patient's medical record.

### 3. Forms of Consultation

- a. Consultation only which leaves the management to the attending physician and prohibits consultants from writing orders on the chart.
- b. Consultation of specific entity or procedure in which the Consultant may write orders to manage the special entity or procedure and may continue to participate in the care of the patient, but overall responsibility remains with the attending physician.
- c. Consultation and Management is transferred to another named physician, in which case patient care responsibilities in the hospital are transferred to the named physician, and the transferring (a.k.a. initial) attending physician may no longer write orders.

### 4. Mandatory Consultations

- a. Admission to the ICU
  - i. Requires consultation with Critical Care Services.
  - ii. Consultation with transfer of management to either; internal medicine, cardiology, interventional neurology, general surgery, neurosurgery or CVT service.
- b. Specific mandatory consultations may also be identified within specific specialty services.

#### **F. Record of Operation and Reports for Invasive Procedures**

1. Operative Report must be documented no more than 24 hours after the procedure.
2. An operative/procedure report is required for any procedure involving moderate sedation, procedural sedation, deep sedation, regional or general anesthesia.
3. Procedures using regional anesthesia must be fully documented with the elements of a dictated operative report.
4. Operative Report must include the following elements:
  - a. Date and Time
  - b. Primary Surgeon/Operator/Assistants
  - c. Pre-operative diagnosis
  - d. Post-operative diagnosis
  - e. Name of surgery/procedure performed
  - f. Type of anesthesia administered
  - g. Description of techniques, findings, tissues, transplants or devices implanted/explanted, if any
  - h. Complications, if any
  - i. Specimens removed (must indicate none if appropriate)
  - j. Estimated blood loss (must indicate none or minimal if appropriate)
  - k. Condition of the patient leaving the Operating Room
  - l. Once the report has been documented, it must be authenticated by the author
  - m. If documented by a resident, NP or PA, it must also be signed by the Attending/Supervising physician.
  - n. If dictated, a Brief Operative note will be documented (hand-written or electronically) in the medical within 30 minutes post-surgery and before the patient is transferred to the next level of care

5. Brief Operative Note must include the following elements:

- a. Date and Time
- b. Primary Surgeon/Operator/Assistants
- c. Pre-operative diagnosis
- d. Post-operative diagnosis
- e. Procedure performed
- f. Type of anesthesia administered
- g. Findings
- h. Specimens removed
- i. Estimated blood loss

#### **G. Progress Notes**

1. **Frequency** - daily progress notes shall be documented for all patients as evidence that the patient is under the care of a physician in an acute care setting.
2. **Content**
  - a. Pertinent chronological documentation of the patient's course in the hospital showing change in the patient's condition and the results of treatment.
  - b. A statement of the patient status, whether improved, unchanged, regressing, etc.
  - c. Any pertinent x-ray or laboratory data, physical findings or addendum to history of present illness.
  - d. Current assessment
  - e. Must be legible if handwritten
  - f. Dated/timed/signed by the author
  - g. 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.
  - h. If a patient left against medical advice, a nurse or physician must document this in the progress note section of the chart.

#### **H. Orders**

1. **Verbal and telephone orders**



- a. Should be limited to situations where the prescriber is not available to enter the order directly into the Medical Record or Electronic Health Record as per *ONE McLaren: Verbal and Telephone Orders Policy (CP 0021)*

## I. Discharge Summary

1. May be handwritten, dictated, or entered into the Electronic Health Record
2. A Discharge Summary is required for:
  - a. All inpatients
  - b. Expirations
  - c. Complicated Deliveries
  - d. Newborn with Complications
  - e. Transfers
  - f. Cesarean Section Deliveries who stay greater than two (2) calendar days
  - g. Observation
  - h. Outpatient Surgery
3. If documented by a resident, NP or PA, must be authenticated by the Attending/Supervising physician.
4. Contents of an Inpatient Discharge Summary shall include:
  - a. Patient identification;
  - b. Attending Physician;
  - c. Admission/Discharge Dates;
  - d. Reason for hospitalization/diagnosis;
  - e. Significant findings including pertinent clinical/diagnostic findings;
  - f. Treatment course, including procedures performed and progress made in regard to specific interventions (i.e., physical therapy, respiratory care, etc.);
  - g. Any complications arising and how they were managed;
  - h. Patient's condition and disposition at discharge;
  - i. Instructions to the patient and family; including instructions for pain management post discharge;
  - j. Provisions for follow-up care, including nutrition, medication, activity, referrals & next appointment if appropriate.

5. Contents of an Observation and Outpatient Discharge Summary shall include:
  - a. Outcome of the treatment, procedures, or surgery
  - b. Disposition of the case
  - c. Provisions for follow-up care to demonstrate continuity of care
  - d. Final diagnosis
6. The Attending Physician is responsible for the Discharge Summary even in the event of the patient's death or departure prior to being seen.

**J. Coding Query**

1. A coding query is completed by a Coder when further documentation or clarification for coding accuracy is needed from the physician.
2. The Coding Query must be answered and documented within seven (7) days of the assignment date.
3. The Attending Physician is responsible for Coding Queries even in the event of the patient's death or departure prior to being seen.

**K. Symbols/Abbreviations in Medical Record**

1. For appropriate use of abbreviations and symbols in the medical record, see "Abbreviation Use in the Medical Record" Policy (01-133).

**L. Deletion/Correction of Documentation**

1. No documents shall be removed from the medical record.
2. For deletions or corrections to the hand written medical record the practitioner will write "error" adjacent to it, strike out with a single line, initial, date and time.

**APPROVAL:**

Recommended: Medical Record Committee: August 24, 2011, August 2013

**APPROVED:** Medical Staff Executive Committee: September 2011, **December 12, 2018**

Revised: August 24, 2011, October 2012, August 2013, December 2015, November 2018

AS/dg: 12/2018