Clark Memorial Hospital

A Norton and LifePoint Partnership

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Owner:	*NAKITA NEAL: HIM - DIRECTOR*
Policy Area:	*HIM - HIM*
References:	
Applicability:	*Clark Memorial Hospital*

Medical Record Completion

PURPOSE:

The medical record needs timely entries if it is to be valuable in the patient's concurrent care. Timely documentation in the medical record of the history, physical and operative reports is particularly important. The medical record is complete when:

1. Its contents reflect the diagnosis(es), diagnostic test results, therapy, patient's condition, in hospital progress and condition at discharge
2. It contains any required operative reports, discharge summary with final diagnosis(es), complications and procedures included
3. Its contents reflect all care given by the interdisciplinary team during the hospitalization

DEFINITIONS:

For the purpose of this policy, the following definitions apply:

MEDICAL RECORD: The account compiled by physicians and other health care professionals of a variety of patient health information, such as the patient's assessment findings, treatment details, progress notes and dictated medical reports

DELINQUENT MEDICAL RECORD: A medical record that remains incomplete with documentation deficiencies thirty (30) days after discharge.

INCOMPLETE MEDICAL RECORD: A medical record with documentation deficiencies that remains incomplete for 1 – 29 days after discharge.

A COMPLETE MEDICAL RECORD: As described under "purpose" of this policy.

POLICY:

Federal, State and Regulatory agencies requires medical records to be completed within 30 days of discharge.

Medical Record Data and information are managed in a timely manner. All significant clinical information pertaining to a patient is entered into the medical record as soon as possible after its occurrence.

Medical Records of discharged patients shall be completed within 1 – 29 days of discharge.

The total number of medical records delinquent for any reason shall not exceed 50% of the average monthly discharges for the entire hospital.

PROCEDURE:

WHO:	DOES WHAT:
Health Information Management	HIM receives or retrieves the medical record from inpatient and outpatient services: a. Assemble and scan medical record into EHR system b. Scanned documents are reviewed and indexed c. Record is analyzed and electronically flagged for deficiencies d. Deficiencies are assigned to appropriate physician(s) for completion
	A count of incomplete charts will be conducted on a bimonthly basis. Physicians will receive a letter listing all incomplete records. The letter will list the hospital numbers, the names of the patients and items that are incomplete in the chart. These charts must be completed prior to the 30th day after discharge. If the charts are not completed by that time, the following steps will be taken: 1. The physician will lose medical staff privileges if he/she has delinquent (older than 30 days post discharge) records. a. Physician will be allowed to perform pre-scheduled operative procedures and care for current inpatients b. If suspended physician is on-call he/she will be required to perform on-call duties 2. If a physician has six or more suspensions for delinquent medical records in any twelve month period, that information will be forwarded to the Medical Executive Committee (MEC) for consideration of possible removal from the Medical Staff. If this occurs, it will be reported to the National Practitioner Data Bank. The MEC also ruled that all delinquent charts must be completed prior to the physician having his/her medical staff privileges reinstated or being granted medical staff privileges/membership in the event that the physician loses all medical staff privileges. 3. Suspensions are posted on ClarkNet

PHYSICIAN:

During the hospitalization or OP surgery encounter, a history and physical examination (H&P), operative report(s), consultation(s), progress notes, and physician's orders shall be documented, dated and signed.

Authenticate verbal orders or telephone orders within 48 hours of the order

After the patient is discharged, complete the medical record in paper or in Sovera if analysis is complete.

a. Complete all documentation described in this policy if it is incomplete at the time of discharge;

b. Write a discharge or death note (if appropriate) in the progress notes;

c. Dictate or complete a discharge summary, short stay summary, or transfer summary (as appropriate).

Complete all discharge medical records within 30 days of discharge

Inform the HIM department of any extended absences from the hospital (for one or more weeks) prior to departure.

MEDICAL RECORD COMPLETION REQUIREMENTS:

DATING AND AUTHENTICATION ENTRIES IN THE MEDICAL RECORD:

All entries in the medical record shall be dated, timed and authenticated by:

a. Written signature

b. Complete key (computerized signature)

c. Today's date and time.

All entries in the medical record shall be dated, timed, and authenticated within 30 days of discharge.

Medical History and Physical Examination

All IP records reflect that durable, legible original or reproduction of a medical history and a completed physical assessment, obtained in the office of a physician or oral and maxillo-facial surgeon on the medial staff, completed within 30 days prior to admission.

A. Any changes in condition **must** be noted on admission or within 24 hours after admission.

B. All H&P's must be completed prior to the patient having surgery, endoscopy, conscious sedation cases or invasive procedures performed

C. When completed before the day of surgery (no more than 30 days prior), the H&P must be reviewed and updated by a physician on the day of surgery **before** the procedure. The examination completed by the Anesthesiologist prior to surgery can be accepted as the updated examination when the H&P has been completed within 30 days of admission, but prior to the day of the procedure.

H&P and updates are to be completed by the following practitioners who have been grated privileges by the hospital:

- MD/DO,
- Maxofacial surgeon for patients admitted only for oromaxofacial surgery,
- PAs and NPs to whom other practitioners have delegated the H&P and update, must still be signed by the MD/OD within 24 hours.

Surgical procedures performed by Podiatrists and Dentists are under the overall supervision of the chairperson for the Department of Surgery.

- Podiatrist provides the podiatric history and physician. A MD/DO provides the same basic H&P as for other patients.
- Dentists provide a dental history and description of the examination of the oral cavity and pre-operative diagnosis. A MD/DO provides the same basic H&P as for other patients.

Newborn physical is completed immediately after birth and includes at least the length, height, weight, and head circumference.

Physicians orders, Verbal orders, and Telephone orders

a. Verbal orders and telephone orders for medications, diagnostic or therapeutic treatment from physicians are accepted and transcribed as outlined in Medication Orders policy.

b. The physician responsible for the patient authenticates such orders, within 48 hours of giving order.

c. All physicians' orders written by the practitioner shall be dated and authenticated at the time the order is written.

Consultation Reports

When a consultation is ordered, the consultant shall:

a. Write or dictate an opinion that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

b. Record the consultation prior to surgery when operative procedures are involved, except in emergency situation.

c. Date and authenticate the consultation report.

Discharge Summary

a. All discharge summaries shall be completed within 1-29 days of discharge.

b. 48 hour discharge documentation summaries (short stay form) may be substituted for a dictated discharge summary in cases where patients with a problem of a minor nature that requires less than a 48 hour period of hospitalization.

c. A transfer summary may be substituted for the discharge summary when patients are transferred to a different level of hospitalization or residential care within the organization. It must be completed prior to the transfer of the patient.

d. All summaries shall be dated and authenticated by the responsible physician.

Operative (or Other Invasive Procedures) Reports

a. When an autopsy or other invasive procedure is performed, an operative report shall be dictated within 48 hours.

b. Immediately following surgery or an invasive procedure note is documented in the progress note with pertinent information.

Autopsy Reports

a. When an autopsy is performed, provisional diagnoses are recorded in the medical record within three (3) days.

b. The complete protocol is included in the record within 60 days.

Attachments:

No Attachments