

CLARK MEMORIAL HOSPITAL	PAGE 1 of 5	RVS	RVW
MEDICAL RECORD COMPLETION	POLICY #:	7/03	10/99
	EFFECTIVE DATE: September 2008	5/06	12/07
AREA: Facility Wide	WRITTEN BY: Deborah J. Davis, RHIT, Director Health Information Management	7/07	10/12
		9/08	
		3/11	
DEPARTMENT: HIM	APPROVED BY: CEO/PRESIDENT	1/12	10/12

Purpose:

The medical record needs timely entries if it is to be valuable in the patient's concurrent care. Documentation in the medical record of the history, physical examination, and operative reports is particularly important. The medical record is complete when (1) its contents reflect the diagnosis, diagnostic test results, therapy, patient's condition, in hospital progress, and condition at discharge; (2) its contents, including any required discharged summary or final diagnosis and complications and (3) its contents reflect all care given by the interdisciplinary team during stay.

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, and progress notes.

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:

JOINT COMMISSION REQUIREMENTS:

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 10% of the average monthly discharges for the entire hospital.

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PROCEDURE:

WHO:

**Health Information
Management Department**

DOES WHAT:

1. At the time of discharge from IP or OP services.
 - a. Review the medical record for deficiencies.
 - b. Assigns physicians deficiencies into Sovera system.

JCAHO states that Medical Records of discharged patients are completed within the time period specified in the Medical Staff rules and regulations not to exceed 30 days.

2. Bimonthly a count of incomplete charts will be conducted and the physician will receive a letter, regardless of the number of charts. The letter will list the hospital numbers of all incomplete charts, 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 instituted:

Step 1: The physician will lose medical staff privileges if he/she has any delinquent records (unless it is results of system issues and/or not analyzed by HIM properly). The physician will be allowed to perform pre-scheduled operative procedures and care for patients previously admitted. In addition, if the suspended physician is the primary care physician or the on-call physician for patient in need of admission from the emergency department, he/she will be allowed to admit the patient.

Step 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 Physician's Quality Improvement Committee (PQIC) for consideration.

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.

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3. Suspensions are posted on Clark Net.

Physician:

1. 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.

2. Read Back and Verify orders must be signed within 30 days of discharge from the hospital.

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

- a. Complete all documentation described in the above 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, 48 hour discharge documentation summary, or transfer summary (as appropriate).

4. Complete all discharge medical records within 30 days after discharge.

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

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)

All entries in the medical record shall be dated and authenticated within 1-29 days after discharge.

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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 and any changes in condition must be noted on admission or within 24 hours after admission. All H&P's must be completed prior to the patient having surgery or invasive procedures performed.

An H&P is also completed before surgical, endoscopy and conscious sedation cases. 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 practioners who have been granted privileges by the hospital:

- MD/DO/Maxillofacial,
- Maxofacial surgeon for patients admitted only for oromaxofacial surgery,
- PAs and NPs to whom other practioners have delegated the H&P and update, which must 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 physical. 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.

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

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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 after discharge.
- b. 48 hour discharge documentation summaries (short stay form) may be substituted for a dictated discharge summary in cases of 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 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.