

CLARK MEMORIAL HOSPITAL	PAGE 1 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08 9/09	7/03 12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12 10/12	10/12

POLICY STATEMENT:

Clark Memorial Hospital recognizes the significance of accurate and complete medical records. Patient records have inherent value for type present as well as future therapy, education, and research. The informational content of medical records is essential to health care providers for planning care and assessing patients' response, to statisticians for analyzing trends, and to administrators for planning facilities, determining services and establishing fees and reimbursement mechanisms.

DEPARTMENTS:

ALL

AFFECTED:

DEFINITIONS:

AUTHENTICATE means to provide the authorship, e.g., written signature, identifiable initials, or computer user code.

A COMPLETE MEDICAL RECORD is a medical record in which (a) content reflects the diagnosis, results of diagnostic tests, therapy rendered, consent(s), progress, and condition at discharge; and (b) contents, including any required summary or final progress note, are assembled and authenticated, with all final diagnoses and any complications recorded without the use of symbols or abbreviations.

DOCUMENTATION is defined as including (a) demographic and billing information and (b) care and patient response.

POLICY:

A medical record is initiated and maintained for every individual assessed or treated. The medical record either incorporates information from subsequent contacts between the patient and Clark Memorial Hospital or it indicates when a portion of the record has been filed elsewhere. Medical record data/information is managed in a timely manner and all significant clinical information pertaining to a patient is entered into the medical record as soon as possible after its occurrence.

CLARK MEMORIAL HOSPITAL	PAGE 2 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

POLICY con't :

Documentation of patient care in a medical record is done by (a) physicians, (b) dentists (c) medical and dental consultants, (d) state of Indiana licensed/registered/certified health care professionals, and (e) students in any of the health professions caring for the patient as part of a clinical practicum. All documentation is done consistent with Addendum 1: Documentation Requirements. Managers of clinical departments may identify additional classifications of personnel who may document in medical records and the extent of the documentation that each classification may do.

All entries in medical records are dated, timed and authenticated. Authentication may be written signature or initials or a computer use code. Use of initials required the department to be able to identify the name of the author. Use of a computer user code requires usage restricted to the person to whom assigned.

The attending physician must document/dictate and authenticate:

- Identification data;
- Medical history, including the chief complaint, details of the present illness, relevant past, social, and family histories (appropriate to the patient's age) and an inventory by body system;
- Summary of the patient's psychosocial needs, as appropriate to the patient's age;
- A report of relevant physical examinations;
- A statement on the conclusions or impressions drawn from the admission history and physical examination; A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate;
- Diagnostic and therapeutic orders;
- Evidence of appropriate informed consent;
- Clinical observations, including the results of therapy;
- Progress notes made by the medical staff and other authorized staff describing day-to-day care, patient's response, change in patient's condition;

CLARK MEMORIAL HOSPITAL	PAGE 3 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

POLICY con't. :

- Consultation reports;
- Reports of operative and other invasive procedures, tests, and their results;
- Reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatments within 24 hours;
- Emergency services report;
- Records on donation and receipt of transplants and/or implants;
- Discharge note or death note;
- Final diagnosis (es);
- Conclusions at termination of hospitalization;
- Discharge summaries;
- Discharge instructions to the patient and/or family, e.g., diet, activity, medications, and follow-up care;
- When performed, results of autopsy; and
- Evidence of known advance directives.

All abbreviations and symbols used for medical record documentation conform to those in the MEDICAL ACRONYMS, EPONYMS & ABBREVIATIONS, Marilyn Fuller Delong, RN,BSN. Where abbreviations and symbols are prohibited (e.g., recording of final diagnoses and procedures performed), such prohibitions are honored.

CMH has developed a list of unsafe abbreviations. The unsafe abbreviations along with preferred documentation are as follows:

Unsafe Abbreviations:

Unsafe	Preferred
Apothecary	Use metric system
Teaspoon	Use # of ml, mg, etc.
Tablespoon	
Grains	
Ounces	
Drams	
Gtt	Use word "drop"
DAT	Diet as tolerated
Trailing zero	Never use a zero after a decimal point (X mg)

CLARK MEMORIAL HOSPITAL	PAGE 4 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

Lacking of leading zero	Always use a zero before a decimal point (O.X mg)
IU	International unit
U	Unit
QD /qd	Daily
QOD	Every other day
MS	Morphine or Magnesium
MS04	Morphine Sulfate
MgSO4	Magnesium Sulfate
UpAT / UAT	Up as tolerated

Only official medical records forms are used (see Policy on Forms Approval). The Forms Committee, or Medical Executive Committee, after approval from the Physician Quality Improvement Committee, have the authority to sanction the use of a form in the medical record and to determine the disposition of non-official forms found in medical records. Staff must ensure that all patient care documentation made on any non-official draft forms is documented on an official medical record form.

CLARK MEMORIAL HOSPITAL	PAGE 5 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

Addendum 1

A. Manual Documentation

1. Permanent ink is used.
2. Blank spaces between entries are crossed out.
3. Each order is dated, timed and authenticated.
4. Errors are corrected by:
 - i. Drawing a line through the error without obliterating it.
 - ii. Writing the word "error", next to the error; and document the reason
 - iii. Dating and initialing the error.
5. Put late entries onto the next available line; add the date, time, and reason that the entry is late.
6. All entries in the medical record are dated, timed and authenticated by written signature or initials, or computer key.
7. The appropriate practitioner authenticates the parts of the record for which he or she is responsible.
8. The medical record indicates when a portion of the record has been filed elsewhere, e.g., New Directions, Microfilmed, etc.

B. Minimum Required Content of Each Medical Record

1. The patient's name, address, date of birth, medical record number, and the name of any legally authorized representative.
2. The patient's legal status for patients receiving mental health services
3. Emergency care provided to the patient prior to arrival, if any.
4. The record and findings of the patient's assessment.
5. A statement of the conclusions or impressions drawn from the medical history and physical examination.
6. The diagnosis or diagnostic impression.
7. The reason(s) for admission or treatment.
8. The goals of treatment and the treatment plan.
9. Evidence of known advance directives.
10. Evidence of informed consent for procedures and treatments.
11. Diagnostic and therapeutic orders, in any.
12. All diagnostic and therapeutic procedures and tests performed and the results.
13. All diagnostic and therapeutic procedures and tests performed, using acceptable disease and operative terminology that includes etiology, as appropriate.

CLARK MEMORIAL HOSPITAL	PAGE 6 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

14. Progress notes made by the medical staff and other authorized individuals.
15. All reassessments, when necessary.
16. Clinical observations.
17. The response to care provided.
18. Consultation reports.
19. Every medication ordered or prescribed for an outpatient.
20. Every dose of medication administered and any adverse drug reaction.
21. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge.
22. Any referrals/communications made to external or internal care providers and to community agencies.
23. All relevant diagnoses established during the course of care.

C. Ambulatory Services Medical Records.

1. For inpatients receiving continuing ambulatory care services, a list of known significant diagnoses, conditions, procedures, drug allergies, and medications; and by the third visit, initiation of the clinical summary list for each inpatient.
2. Accurate, complete, and signed description of the techniques and findings of every operative procedure performed, dictated, or written immediately following surgery.

NOTE: Reports must contain the same criteria elements as specified in Points G and H below.

3. In the same location in each patient's medical record, have a legible summary – Clinical Summary consisting of:
 - i. List of significant past surgical procedures.
 - ii. Past and current diagnoses or problems.
 - iii. Current and recently used medications.

D. Emergency Services Medical Record:

1. All prior, pertinent, inpatient and ambulatory care, medical record documentation and documentation of previous visits to the emergency services are available whenever possible, when requested by a physician or other authorized individual.
2. The following information for each Emergency Services visit includes:

CLARK MEMORIAL HOSPITAL	PAGE 7 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

- i. Patient identification with documentation of the reason if not obtainable.
- ii. Time and means of arrival.
- iii. Chief complaint.
- iv. Pertinent history of the illness or injury.
- v. Physical findings, including the patient's vital signs.
- vi. Emergency care given to the patient prior to arrival.
- vii. Diagnostic and therapeutic orders.
- viii. Clinical observations, including the results of treatment.
- ix. Reports of procedures, tests, and results.
- x. Diagnostic impression.
- xi. Conclusion at termination of the evaluation/treatment including final disposition, the patient's condition on discharge or transfer, and any instructions given to the patient and/or family for follow-up care.
- xii. Patients leaving against medical advice.

3. Are signed and dated.

- i. Prior to discharge from Emergency Service Department.
- ii. Prior to admission to an inpatient unit.
- iii. Prior to transfer to Ambulatory Care.

4. When authorized by patient, his or her legally authorized representative, a copy of the record of emergency services provided is available to the practitioner of medical organization responsible for follow-up care.

E. Inpatient Medical Records:

1. Documentation of history and physical examination.

- i. Is completed within the first 24 hours after admission.
- ii. Includes:
 1. Chief complaint.
 2. Details of the present illness including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past, social, family history (appropriate to patient's age), and physical status.
 3. Inventory of body systems.

CLARK MEMORIAL HOSPITAL	PAGE 8 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

4. Physical Exam.
5. Conclusions or impressions.
6. Course of action planned for the patient for this episode of care and of its periodical review as appropriate.
7. Reason for admission or treatment.
8. The goals of treatment.

2. Documentation of Progress:

- i. Is written at least daily.
- ii. Pre-operative documentation: Includes the rationale for a planned operative procedure and the name of the procedure to be performed.
- iii. Post-operative documentation: Describes the procedure performed, the findings, specimens removed, and the pre- and post-operative diagnoses.

3. Discharge Documentation:

- i. 48-Hour Discharge Documentation Summary:
 1. May be substituted for a dictated Discharge Summary in the cases of patients with problems of a minor nature that required less than a 48-hour period of hospitalization.
 2. Must include instructions given to the patient and/or family.
 3. In the case of normal newborns and uncomplicated obstetrical cases, as Physician Newborn Record, in conjunction with the Mother-Baby Education and Discharge instructions and a thorough discharge progress note that includes the final diagnosis may be substituted.
 4. Authenticated by the responsible physician.
- ii. Discharge Summary:
 1. Principal with secondary diagnoses with the concise recapitulation of the reason for hospitalization.
 2. Significant findings, the procedures performed, and treatment rendered.

CLARK MEMORIAL HOSPITAL	PAGE 9 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

3. Condition of the patient on discharge, so stated that measurable comparison with condition upon admission can be made.
4. Specific instructions to the patient and/or family, with consideration given to instructions relating to physical activity, medication, diet, and follow-up care, and when printed instructions are provided, the medical record so indicates.
5. Authenticated by the responsible physician.

iii. Transfer Summary:

1. A transfer summary may be substituted for the discharge summary if the patient is transferred to a different level of hospitalization within the organization.

iv. Discharge Against Medical Advice: Assuming that the patient is competent:

1. Discussion of the issues.
2. Advice about alternatives of staying in the hospital, risks of not staying, and diagnosis.
3. Instructions about medications, diet, activity, and return appointments.
4. Evidence of patient's or guardian's understanding.

v. Voluntary Departure without Physician's Prior Knowledge:

1. Physician documentation: Progress note detailing the circumstances of the patient's departure.

F. Consultations:

1. Contain a documented opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.
2. Are recorded prior to surgery when operative procedures are involved except in emergency situations.
3. Authenticated by the responsible physician.

CLARK MEMORIAL HOSPITAL	PAGE 10 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

G. Informed Consent (Form and Progress Note):

1. Identification of the patient.
2. Date the consent is signed.
3. Diagnosis (es).
4. Procedure or treatment (in Laymen's terminology when possible).
5. Name (s) of the individual (s) who performs the procedure or administers the treatment.
6. Authorization for any required anesthesia.
7. Indication that alternatives are explained.
8. Indication that the possibility of risks or complications are explained.
9. Authorization for disposition of any body tissue or body parts as indicated
10. Documentation that the patient verbally understands the above elements and the meaning of the consent. When consent is not obtainable, the reason is documented in the medical record.
11. Documentation of refusal to consent.
12. Possible risks of refusal that were disclosed to patient.
13. Practitioner with clinical privileges, who informs the patient and obtains consent, will be identified by signing the authorization.
14. Signature of the patient or other individual empowered to give consent and a witness to that signature on the consent form.
15. Dated signature of witness on the consent form.

H. Operative or Other Invasive Procedures and/or Anesthesia:

1. The licensed practitioner who is responsible for the patient records a pre-operative diagnosis prior to surgery.
2. Operative reports are dictated or written in the medical record immediately after surgery and describe the findings, the technical procedures used, the specimen removed, the post-operative diagnosis, and the name of the primary surgeon and any assistants.
3. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery.
4. When the operative report is not placed in the medical record immediately after surgery (for example, there is transcription and/or filing delay of more than six (6) hours), an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.
5. Post-operative documentation includes at least a record of:

CLARK MEMORIAL HOSPITAL	PAGE 11 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

- i. Vital signs and level of consciousness.
- ii. Medications (including intravenous fluids) and blood and blood components.
- iii. Any unusual events or post-operative complications, including blood-transfusion reactions, and the management of those events.
- iv. Identification of whom provided direct patient care nursing services and who supervised that care if it was provided by someone other than a qualified registered nurse.
- v. Patient's discharge from the Post-anesthesia care area by the responsible licensed independent practitioner.
- vi. Name of the licensed practitioner responsible for the discharge.

I. Anesthesia:

1. Pre-anesthesia documentation includes:

- i. Informed relative to the choice of anesthesia and surgical or obstetrical procedure anticipated, recorded prior to the patient's transfer to the operating area and before medication is administered except in extreme emergencies.
- ii. Type of anesthesia anticipated, i.e.: general, spinal, regional or local.
- iii. Patient's previous drug history, other anesthesia experiences, and potential anesthetic problems.

2. Post-Anesthesia documentation includes:

- i. At least one note describing the presence or absence of anesthesia related complications.
- ii. Date, time and signature or anesthesiologist.

J. Donor and Recipients of Transplants:

1. When an organ is obtained from a live donor for transplantation purposes, the medical records of the donor and the recipient fulfill the requirements for any surgical inpatient medical record.
2. When a donor organ is obtained from a deceased patient, the medical record of the donor includes:

CLARK MEMORIAL HOSPITAL	PAGE 12 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

- i. Date and time of death.
 - ii. Documentation by and identification of the practitioners who determined the death.
 - iii. Method of transfer of organ.
 - iv. Method of machine maintenance of the patient for an organ donation.
 - v. Operative Report.
 3. When a cadaveric organ is removed for purposes of donation, there will be an Autopsy Report that includes a description of the technique used to prepare or preserve the donated organ.
- K. Transfer of Patient from One Clinical Specialty to Another and from One Unit to Another:
1. Includes an order with:
 - a. Date and time of transfer.
 - b. Specialty/service/unit receiving patient.
 - c. Name of receiving units.
 - d. Authentication.
 2. Includes assessment of patient status upon arrival in receiving unit.
- L. Assessment of Patient Receiving Treatment for Alcoholism or other Drug Dependencies:
1. A history of the use of alcohol and other drugs; including age of onset, duration, patterns, and consequences of use.
 2. The history of physical problems associated with the dependence.
 3. The use of alcohol and other drugs by other family members.
 4. The spiritual orientation of the patient.
 5. The types of previous treatment and responses to that treatment.
 6. Any history of physical abuse.
 7. The patient's sexual history, including sexual abuse (either as the abuser or the abused), and orientation

CLARK MEMORIAL HOSPITAL	PAGE 13 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

M. Assessment of Victims of Alleged or Suspected Abuse or Neglect:

1. Conducted with consent of the patient or legal guardian or an otherwise provided by law.
2. Is conducted in accordance with Clark Memorial Hospital responsibility for the collection, retention, and safeguarding of evidentiary material released by the patient.
3. Includes, as legally required the notification and release of information to the proper authorities.

N. Assessment and Reassessment of Infants, Children, and Adolescents Specifically Include:

1. The patient's developmental age, length and height, head circumference, and weight.
2. Consideration of educational needs and daily activities.
3. The patient's immunization status.
4. The families and/or guardian's expectations of and involvement in the assessment, initial treatment, and continuing care of the patient.

O. Special Treatment Procedures:

When using care interventions, of particular interest with respect to patient rights and risk management, such as aversive therapies, and restraint and seclusion, special documentation requirements must be met.

1. Documentation in the progress note shall address:
 - i. The patient's physical, behavioral, cognitive, communicative, emotional, pharmacological, and social needs.
 - ii. Goals and objectives of the treatment.
 - iii. A description of facilitating factors and possible barriers to reaching the goals and objectives.
 - iv. The identification of interventions expected to result in desired and attainable goals and objectives.
 - v. The patient's response to intervention, change in the patient's condition: choice for alternative interventions or treatments, and progress in meeting the goals and objectives.
2. Physician orders shall reflect the hospital restraint policy.

CLARK MEMORIAL HOSPITAL	PAGE 14 of 14	RVS	RVW
MEDICAL RECORD DOCUMENTATION	POLICY #:	12/99	9/97
	EFFECTIVE DATE September 1995	4/06	12/99
AREA: HIM	WRITTEN BY: Debbie Davis, Director Health Information Management	8/08	7/03
		9/09	12/07
DEPARTMENT: All	APPROVED BY: CEO/President	1/12	10/12
		10/12	

P. Advance Directives:

1. In collaboration with his/her physician, the patient has the right to accept medical care or refuse treatment to the extent permitted by law. And to be informed of the medical consequences of such refusal and the right of the patient to formulate advance directives and appoint a surrogate to make healthcare decisions on his/her behalf to the extent permitted by law. Any advance directive(s) in the patient's medical record is reviewed periodically with the patient or surrogate decision-maker.
 - i. The progress notes document evidence of advance directives.
 - ii. The medical record contains appropriate orders by the physician primarily responsible for the patient when resuscitative services are to be withheld or life-sustaining treatment is to be withdrawn.
 - iii. All documentation is consistent with Policy and Procedure on Advance Directives.

Q. Respiratory Care Services:

1. Respiratory care services are provided to patients in accordance with a written physician's order that is dated and authenticated.
2. Respiratory Therapists shall document treatment and response to treatment in the medical record. When oxygen therapy is ordered by the physician for newborns, the inspired oxygen is to be measured per respiratory therapy protocol.

Addendum 2

For the Electronic Health Record (EHR) documentation refer to the appropriate user manual:

1. Sunrise Acute Care (SAC) – located on ClarkNet, under Resources. Acute Care (SAC) student manual.
2. OB TraceVue (OBTV) – located in Nas/Public and on applicable computers.
3. Surgical Information System (SIS) – “Help” section within the application.