

MEDICAL STAFF STANDARD # 4

SUBJECT: Medical Records

RESPONSIBLE PERSONS: St. Ann's Medical Staff

POLICY:

It is the policy of the medical staff to ensure timely completion of medical records in accordance with regulations and quality-of-care. A sample of reports will be monitored on a concurrent basis to ensure timely documentation. Results of these monitors will be reported monthly to Clinical Care Council.

DEFINITIONS

Timely = 30 days post discharge.

Incomplete = Any deficiency in the medical record within 30 days post discharge.

Delinquent = Any record that is incomplete at 31 days post discharge.

H&P = The collection of information about the patients medical history and physical findings sufficient for safe care of the patient. The required content may vary by location and clinical setting.

HISTORY & PHYSICAL (H&P)

The history and physical examination is viewed as the basic information about the current status of the patient's health. The documentation of the H&P is a key communication tool for staff and providers caring for the patient. The medical staff member who has assumed responsibility as the attending physician is responsible for the content and quality of the H&P documents.

The medical staff organization is responsible for monitoring this policy.

The documents generated for histories and physicals may take several forms.

- **PREPRINTED TEMPLATE FORMS** that have been approved by the Clinical Care Council and the Mount Carmel Health System Forms Committee.
 - **HAND WRITTEN H&P** must be clearly identified as the H&P and be legible.
 - **OFFICE NOTES OR CONSULTATIONS** containing H&P performed within 30 days, with an update that is to have occurred within 24 hours of hospital admission prior to the procedure
 - **Dictated / Transcribed Documents** reflecting the history and physical assessment done within 24 hours of hospitalization
 - **EXTRACTED H&P** from the Emergency Department record
- ***The forms used in support of this policy are attached

The H&P must meet the following basic requirements of content and timeliness:

H&P - CONTENTS

- History of present illness
- past medical and surgical history
- allergies
- current medications

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- relevant family history
- relevant social history
- pertinent review of body systems
- physical examination including the system and relevant site impacted by any potential surgical or invasive procedure
- clinical impression
- treatment plan
- signature/date/time

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H&P UPDATE (MCSA) / INTERIM NOTE

This form is to be used for any chart containing a physical exam done prior to the patient arriving at the hospital, as long as the H&P has been done within 30 days (update). If the H&P was performed prior to 30 days it must be repeated and recorded as new. The form should also be used to document pertinent findings if the physician has chosen to dictate the H&P and it is not immediately available on the chart. It provides documentation of the method used to provide the H&P as well as the place to document interim changes, impression and plan.

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This document should be completed when an H & P has just been dictated and is not immediately available. This document is not required but encouraged as a communication tool when dictated information is not available. If the physician notes the essential information in the chart e.g. progress note, the interim note /update form is not necessary.

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H&P TIMELINESS

Elective hospitalizations must be accompanied by a history and physical performed within 30 days. This history and physical must be supplemented by an update performed within 24 hours of the hospitalization.

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Unplanned hospitalizations must have a history and physical performed within 24 hours.

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SURGICAL OR INVASIVE PROCEDURES

Pre Procedure Notes

A History and physical must be performed prior to any surgical or invasive procedure.

An interim note can be used on the chart before the procedure to document clinical impression and plan if the H&P is already completed or dictated report is pending. If the H&P was done prior to the hospitalization it must be updated within 24 hours of arrival at the hospital. Completion of the interim note / update document is sufficient for this purpose. There is no requirement that a H&P performed or appropriately updated during this hospital stay be updated a second time prior to surgery.

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The record must reflect sufficient information to safely care for the patient prior to a procedure or surgery.

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Post Procedure Notes

A post procedure progress note must be completed immediately after all procedures. The procedure report must be dictated within 24 hours of the procedure. If the procedure report is done immediately and is available immediately no post procedure note is necessary.

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All procedure reports include but are not limited to:

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|-------------------------|-------------------------------------|
| operative reports | electrophysiology study (EPS) |
| endoscopy reports | pacemaker insertions |
| cardiac catheterization | interventional radiology procedures |

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All operative reports (written or dictated) must contain:

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| Preoperative clinical impression | Specimens Removed |
| Findings | Post-Op Diagnosis |
| Technical procedures used | Name of Surgeon/Assistant(s) |
| Estimated blood loss | Signature/Date/Time |

DISCHARGE SUMMARY

Discharge summaries are the responsibility of the attending or their physician designee. **Orthopedic House Staff are not considered the "attending"** and are required for all patients staying in the hospital over 24 hours. All CDU patients require a written or dictated discharge summary. All ambulatory surgery patients require at a minimum the written discharge form.

Written or Dictated Discharge Summary: is required for:

- patients hospitalized five (5) days or less
- must be completed prior to discharge
- should be reserved for those patients with a less complex hospital course.
- must be on an approved form (see attached).

Dictated Discharge Summary: is required for:

- patients staying greater than five (5) days
- must be complete and authenticated in less than or equal to 30 days.
- a hospital stay with a complex or unusual course should have a dictated summary.
- all deaths are required to have a dictated discharge summary and include the events leading to death.

Contents of a Written or Dictated Discharge Summary :

- reason for hospital admission
- significant findings
- procedures performed
- treatment rendered
- condition on discharge
- summary of subsequent plan and follow up
- events leading to death (if applicable)

Transferred Patients: patients being transferred outside of Mount Carmel St. Ann's, require a discharge summary. A written note which will accompany the patient must be provided if dictation / transcription is used. The patient should be transferred with sufficient documentation of history and physical findings and course of hospitalization available to any subsequent practitioner, to facilitate safe and effective care.

ABBREVIATIONS

No order will be acted upon until it is free of "do not use" abbreviations, unless the potential harm from delay is greater than the potential harm from error. Please refer to the list of "Unapproved Abbreviations" located on the Mount Carmel intranet "InSight."

AUTHENTICATION

All entries in the medical record must be authenticated by authorized practitioners. Section 482.24 of the current Medicare conditions of Participation for Medical Record Services, indicates that all medical records must be authenticated and that "authentication may include signatures, written initials, or computer entry." Signature stamps are not permitted. All authentications must include signature date and time.

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ORDERS

Use of verbal and telephone orders will be minimized and avoided whenever possible.

All verbal and telephone orders should be signed/date/timed by a practitioner responsible for the care of the patient as soon as possible but within 48 hours while the patient is admitted.

Verbal and telephone orders for restraints and code status must be signed/dated/timed by a practitioner responsible for the care of the patient within 24 hours.

Verbal and telephone orders given day of discharge should be authenticated by the practitioner no later than 30 days post discharge.

All orders must be given or signed by a licensed physician, dentist, or podiatrist including telephone orders dictated to a licensed registered nurse, a licensed respiratory care professional, a licensed dietician, or a registered pharmacist and must be signed by an authorized practitioner.

When physicians in training or other specified professional personnel are involved in patient care, sufficient evidence must be documented in the medical record to substantiate the active participation in and supervision of the patient's care by the responsible attending practitioner. The document must be signed by the responsible supervisor.

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PROGRESS NOTES

A progress note written, by the attending practitioner or their physician delegate, should be entered into the medical record at least daily and more frequently if warranted by the patient's condition.

OWNERSHIP

All original medical records are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping, except in accordance with court order, subpoena, or stature. Copies of the patient's medical record may be furnished to the patient or the patient's designate upon the patient's written request and at the patient's expense.

CONFIDENTIALITY OF PATIENT RECORDS

A practitioner's access to patient records is limited to necessary use in the treatment of patients, scientific study, or to peer review activities. All practitioners are required to maintain the confidentiality of patient records and improper use or disclosure of patient information may be grounds for corrective action. ***(Refer to Medical Staff Policy "HIPAA Notice of Privacy Practices and Joint Use of Patient Information")***.

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BIRTH CERTIFICATES

Completed Birth Certificates are to be signed by the physician within 10 days.

DEATH CERTIFICATES

Death certificates are the responsibility of the attending physician regardless of whether they were the practitioner who pronounced the patient deceased.

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DELINQUENT MEDICAL RECORDS

Any physician or dentist will be **AUTOMATICALLY RESIGNED** for either of the following:

- **Six (6) occurrences in delinquent status in the past 12 months;**
- or
- **One (1) chart greater (>) than 90 days old**
**** *this overrides any accumulated occurrences*

A DICTATED CHART IS NOT CONSIDERED COMPLETE UNTIL IT HAS BEEN SIGNED AND DATED.

1) **Six Occurrences In The Past 12 Months:**

A physician or dentist will be automatically resigned if they have six (6) occurrences in delinquent status in the past 12 months.

Delinquent Record Status: Any physician or dentist with more than 10 medical records incomplete more than 30 days after discharge shall be placed in delinquent record status until the delinquent records are complete.

Occurrence: Delinquent record status shall be counted as **one** occurrence per week.

Removal of 1 Occurrence: A practitioner with previous occurrences may have one occurrence removed if they have four (4) consecutive weeks with no occurrences.

Removal Of All Occurrences: Every January all occurrences for all practitioners will be removed.

Excused Occurrences: With the approval of the President of the Medical Staff or designee, a physician may be excused from accumulating occurrences temporarily due to various reasons (maternity leave, extended medical leave, out of the country, etc).

Notification Process

Weekly

Health Information Management will:

- FAX the affected practitioner a notice to their primary office of the records that remain delinquent.
- EMAIL the Medical Staff Leaders, Administration and the Medical Staff Office with the delinquent records report and summarize the names of those who have **3** or more occurrences and/or 1 chart >90 days old.

Medical Staff Office will:

- Call the respective Department Chair and notify them of the names of their members who have 3 or more occurrences and/or charts >90 days old, and fax or email the list of delinquent charts to them.
- Send a certified letter to those practitioners who have charts >90 days **and/or** 6 or more occurrences.

Department Chair or Designee will:

- Call affected practitioner, review the policy with them and notify them that they are in danger of a automatic resignation. If the Chair is not available to contact the member, another Medical Staff Leader, Administration or the Medical Staff Office will contact the physician.

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Upon Six Occurrences

Medical Staff Office will:

- Call Manager of HIM to verify the practitioner has 6 occurrences and/or charts >90 days.
- Contact Medical Staff Leadership/Administration to verify that we are to proceed with sending a certified letter to the practitioner notifying them that they will be forwarded to the next regularly scheduled Credentials Committee, Medical Executive Committee and Board of Trustees for automatic resignation.

2) If a practitioner has one (1) chart > 90 days delinquent the provider will be automatically resigned.

At Sixty (60) Days:

The Physician will be notified at the **60 day** mark of the chart delinquency reminding them that if it should reach 90 days it will be considered an **automatic resignation** from the medical staff.

Health Information Management will fax the 60 day notification to thy physician's primary office, and notify the Medical Staff Leadership/Medical Staff Office;

At Ninety Days (90) Days: >>>> AUTOMATIC RESIGNATION

Health Information Management will notify the Medical Staff Office and Administration via email of the names of those practitioners who continues to have (1) chart > 90 days old.

Medical Staff Office will with the approval of the Medical Staff Leadership and Administration, the MSO will forward the names of the practitioners who will be recommended for automatic resignation to next regularly scheduled Medical Executive Committee and Board of Trustees for **automatic resignation**.

Delinquent record status shall be strictly enforced.

REINSTATEMENT CLAUSE:

TEMPORARY PRIVILEGES: Provided all records are completed (dictated & signed) he/she shall have the opportunity to apply for temporary clinical privileges.

a) Temporary privileges may be granted by the COO, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following: (i) the care of a specific patient; (ii) an individual serving as a locum tenens for a member of the Medical Staff; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty service area.

b) If an additional chart becomes > 90 days old during the time of temporary privileges, the practitioner will be automatically resigned again and will not be afforded the privilege of re-applying for temporary privileges.

FULL APPLICATION: The practitioner may re-apply for full privileges and must be credentialed through the same process as if they were a new applicant. They will pay the application fee, provide all necessary documentation and will be placed in a two (2) year provisional period once their application has been approved by the Credentials Committee, Medical Executive Committee and the Board of Trustees.

DEVELOPED BY: St. Ann's Medical Staff **ORIGINAL DATE:**

REVIEWED/REVISED DATE: 12/02, 3/03, 7/03, 1/05, 5/05, 8/05, 10/05, 9/07

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REPLACES: Med Staff Rules & Regulations
/Medical Record Completion Policy

REVIEWED BY: Medical Executive Committee, 3/03, 1/05, 5/05, 8/05, 10/05,
9/07, 11/07

APPROVAL FOR IMPLEMENTATION BY: MCSA Board of Trustees 3/03, 3/05, 6/05, 9/05, 12/05, 9/07,
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