

I. PURPOSE

To describe the medial components of a complete and legible medical record, which is current and pertinent for each patient admitted for inpatient or outpatient services. This includes portions of the paper medical record, as well as the portions that are electronic.

II. POLICIES**A. All Admissions**

1. The record shall include identification and social data; complaints; a complete medical history; history of present illness; physical examination; special reports such as consultations and clinical laboratory, radiology, and other services; provisional diagnosis; plan for patient care; medical or surgical treatment; properly executed informed consents; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary; and autopsy report as applicable.
2. A history and physical examination must be completed as outlined in the Medical Staff Rules and Regulations.
3. Records of children and adolescents shall also include head circumference if appropriate (under two years of age); evaluation of the patient's developmental age; consideration of the educational needs and daily activities as appropriate; parents' report or other documentation of patient's immunization status; and the family's or guardian's expectations and involvement in the assessment, treatment, and continuing care of the patient.
4. Progress notes must provide pertinent chronological information concerning the patient's course of treatment, shall be recorded at the time of observation, and shall be sufficient to permit continuity of care and transferability.
5. Each of the patient's clinical problems will be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatments.
6. All patients must be assessed daily by the attending practitioner or designee and this review must be documented on the patient's medical record.
7. Progress notes shall be written at least daily or more frequently where there is difficulty in diagnosing or managing the clinical problem.
8. The planning for care and treatment is collaborative and interdisciplinary with the focus on individualized care, which meets patient care goals.

9. Properly executed informed consent forms will be obtained from patients and monitored for accuracy.

B. Operative Reports

1. Shall include the preoperative diagnosis, procedures(s) performed, note of specimens removed, a detailed account of the findings at surgery, the details of the surgical technique, any complications, a specified postoperative diagnosis, and the name of the surgeon and assistant.
2. Operative reports shall be dictated immediately following surgery and the report signed.
3. When the operative report is dictated, a written summary of the surgical procedure including operative procedure, findings, specimen(s) removed, postoperative diagnosis, any complications, blood loss and the name of the surgeon and assistant will be documented in the medical record immediately following surgery to provide pertinent information for the use of any individuals who is required to care for the patient.

C. Consultations (See also the Medical Staff Rules and Regulations)

1. Shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations.
2. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant.
3. When operative procedures are involved, the consultation note shall, except in emergency situation noted in the record, be recorded prior to the operative procedure.

D. Emergency Record

1. The record shall include adequate patient identification; the time of the patient's arrival, means of arrival, and by whom transported; pertinent history of the injury or illness including details relative to first aid or emergency care given prior to his/her arrival in the emergency room; description of significant clinical, laboratory, and radiologic findings; diagnosis; treatment given; condition of the patient on discharge or transfer; and final disposition including instructions given to the patient and/or his or her significant other for follow-up care.
2. Physicians may document their history, physical findings and treatment either by dictated

reports and/or may enter an ER report in First Net. Physicians must authenticate by electronic signature the dictated report or the ED Record.. The face sheet contains the demographic information only and does not need to be signed by the physician.

E. Final Diagnosis

1. Will be recorded in full, without the use of symbols or abbreviation.

F. Discharge

1. A discharge summary shall be written or dictated for all Acute and Swing Bed skilled inpatients.
2. A patient's medical record shall be completed at the time of discharge, including progress notes, final diagnosis, and discharge summary.
 - a. The discharge summary is to include reason for admission; significant findings; hospital course; condition on discharge; discharge instructions (diet, medications, physical activity, and follow-up); and final diagnosis.
 - b. When this is not possible because of laboratory or other essential reports have not been received at the time of discharge, the patient's record will be available in a place designated by medical records personnel.
3. The content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and outcome.

G. Orders on Medical Records

1. Physician will enter orders into the electronic record by use of Care Sets, favorites or individually, and must be authenticated by him/her with electronic signature.
2. Any physician orders written on paper must be dated, timed and signed by the physician.
3. The practitioner's orders must be written clearly, legibly, and complete. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse, pharmacist or other authorized hospital personnel.
4. A verbal order or phone order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere or competence and authenticated by the responsible practitioner within 30 days of the order being verbally given or over the phone.
 - a. Authorized personnel include registered nurses (who may take all verbal orders), pharmacists, respiratory therapists, physical therapists, speech pathologists, occupational

therapists, dietitians, registered laboratory personnel, and radiologic technologists may accept and transcribe verbal orders in their area of specialty.

- b. All verbal orders, whether written or entered in the electronic record, taken by an authorized person, shall be signed by that person and shall include the name of the practitioner, the date, the time, and the name of the practitioner giving the verbal order.
5. If a nurse has any reason to doubt or question a medical order and he/she is ethically or legally unable to carry out the order, he/she will notify the Patient Care Coordinator who will, in turn, notify the Director on Call. This person will notify the President of the Medical Staff.
 - a. The administrative person and the Medical Staff officer will, after conferring, contact the attending physician to review the situation and reach an appropriate resolution.
 - b. Appropriate follow-up and/or disciplinary action will ensue.

H. General Policies

- a. All clinical entries in the medical record must be dated, timed, and authenticated. (Authentication means to establish authorship by written signature or identifiable initials or electronic signature.)
 - b. Signature stamps are **not** accepted in lieu of an original physician signature. Signatures must be originally or electronically signed.
 - c. Practitioners, for electronic usage, must certify by signature that he/she will be using an electronic signature to sign medical records, he/she will have their personal password, edit such reports and be the only person to utilize his/her password to sign reports.
2. Symbols and abbreviations may be used only when they have been approved by the Medical Staff.
 3. A patient may have access to his/her medical record according to medical record policies and procedures according to Federal, State and HIPAA regulations.
 4. Written consent of the patient or the patient's legal representative is required for the release of medical information to persons not otherwise authorized to receive this information.

5. Access to all medical records of patients shall be afforded to members of the Medical Staff for educational purposes, care evaluation, utilization review, quality review, research, and consistent with preserving confidentiality of information.
 - a. All such projects shall be approved by the Medical Staff prior to records being studied, except for the purpose of quality review activities.
 - b. Records in litigation or in potential litigation may be reviewed or worked on only in the presence of the Director of Mercy Medical Center-Dyersville, Health Information Management Supervisor or designee, or Risk Management.
6. Original medical records may be removed from the hospital jurisdiction only in accordance with a court order, subpoena, or statute.
 - a. Copies may be made according to hospital and HIM Department policies and procedures.
7. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Professional Activities Committee and Medical Staff Executive Committee.
 - a. No medical record shall be considered complete until certified so by the signature of the attending physician.
8. The medical record will be completed at the time of discharge, including progress notes, final diagnoses and dictated clinical resume. When this is not possible, the patient's record will be available in the Health Information Management Department after discharge.
 - a) The electronic portions of the medical record are available through Cerner PowerChart.
9. When an error in documentation is made within a patient's medical record, a single straight line is drawn through the entry, the word "error" is written next to the entry, the current date,
with the initials or signature of the documenter.
 - a) Entries in the electronic record can be errored or addendum added according to accepted Power Chart procedures.
10. When an addendum is made, the entry is labeled "addendum" or "late entry," the current date is noted as is the original date to which the late entry is referencing with the initials or signature of the person completing the documentation and the entry is timed.

I. Delinquent Records:

Medical Records will be considered delinquent when they are 15 days past-due following discharge. On Tuesdays of each week, a letter is sent to each Medical Staff member who has four or more records overdue or when any records are 30 days overdue. That letter contains the number of records over ten days old or older and the number of suspensions the Medical Staff member has received within this twelve-month period. On Friday, a reminder telephone call is made to the office

if those records remain incomplete. On Monday at 1200 hours, if those records (now at least 15 days overdue) are still incomplete, the Medical Staff member's admitting and surgery scheduling privileges are suspended until the records are completed. If the Medical Staff member is on vacation during the time 10 day records are identified and he/she has notified the Medical Record Department before leaving, he/she is not placed on the delinquent list. If the Medical Staff member is on the list before a vacation, he/she is kept on the list until the records are completed. As soon as the records are completed and an employee of Medical Records is notified, the Medical Staff member is removed from that list.

If at any time a medical record is not available for a Medical Staff member, the age of the record is set back to zero and will not count against the Medical Staff member.

Suspensions: Follow procedure outlined in the Medical Staff Rules and Regulations.