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Professional Services Memorandum

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Medical Record Documentation

Purpose:

This policy establishes standards for the timely and accurate completion of Medical Records within the Milwaukee VA Medical Center and its associated clinics. For the rest of this document "Milwaukee VAMC" will refer to the Milwaukee VAMC and all its associated clinics, including the Community Based Outpatient Clinics (CBOCs).

Policy:

The Department of Veterans Affairs medical record will reflect the highest quality of care, comprehensiveness, clarity, interdisciplinary communication, research, training and patient education. Electronic storage and capture of patient medical information will be implemented to the extent possible to enhance access to patient data by health care providers and support personnel. The electronically stored and/or printed patient information is subject to the same medical and legal requirements as the handwritten information in the medical record.

Responsibility:

A. Although the Attending Staff Physician has overall responsibility for the care of the patient, each provider is responsible for the accuracy of the medical record for each patient under his or her care as well as the accuracy of entries of those under their supervision, e.g. students, trainees.

B. Health care providers shall be responsible for completing their respective notes for patients under their care and protecting the confidentiality of the medical record.

C. All Milwaukee VAMC employees who are involved with direct patient care are responsible for documentation, including authentication, of patient care activities in the Computerized Patient Record System (CPRS)

Procedure:

A. General Guidelines

1. The primary source of documentation for all patient care activities within theMilwaukee VAMC will be the CPRS.

    a. Access to CPRS by authorized clinical or administrative users is based on the user's job function, role responsibilities, and specific reason the information is required to perform the user's job function. Users are required to comply with all privacy, information security awareness and rules of behavior requirements.

b. Electronic input of data, in conjunction with the VISN 12 initiative to achieve a complete electronic medical record, should be explored in all cases where a manual system of entry still exists.

c. Documentation electronically maintained and available within the CPRS should not be unnecessarily printed by clinical or other users. Routine creation of printed hardcopy documents of electronically maintained information is an inappropriate use of facility resources and increases risks related to patient privacy. Documents available electronically within CPRS should only be printed in preparation for a scheduled CPRS downtime or similar non-routine cases.

1. The Milwaukee VAMC medical record is comprised of progress notes, assessments, history and physical examinations, laboratory reports, radiology reports, consults, interdisciplinary treatment plans, Medication Administration Records, and other necessary documents to assist with quality patient care. At a minimum, the following information is available to those involved in medication management: the patient's age; sex; current medications; diagnoses, comorbidities, and concurrently occurring conditions; relevant laboratory values, allergies and past sensitivities. Where appropriate to the patient, the weight and height, pregnancy and lactation status are also available.

   a) All forms including progress note templates, which become part of the medical record, must receive prior approval of the Health Information Management Committee (HIMC). Requests for new forms should be limited to those forms that can be entered into electronic format. Requests should be forwarded to the Health Information Management Committee, Forms/Templates Subcommittee.

   b) The use of symbols and abbreviations will be kept to a minimum. Medical abbreviations listed in the Milwaukee VAMC Unacceptable Medical Record Abbreviations policy (PSM III-3) will not be used. Final diagnoses and procedures shall be recorded in full, without any symbols or abbreviations.

   c) When there is a history of allergies, adverse reactions or other conditions, which, in the physician's opinion, merits special attention, the information will be immediately placed in the medical record.
   d) When preprinted instructions are given to the patient or designee, the record should so indicate.

3. In all cases, the medical record must clearly demonstrate the active involvement of the Attending Physician.

   a) Medical record entries should be made at the time the care is provided. To ensure compliance with the Veteran Affairs seven-day national closeout requirement, all documentation must be completed within 4 days of the discharge of a patient. The Joint Commission considers a medical record to be delinquent when not completed and/or signed within 30 days including Discharge Summary, History and Physical Examination, Operative Report, and/or Consultation. The Health Information Management Committee monitors compliance with these requirements. The Attending Physician must complete all incomplete medical records, within 30 days, to avoid designation as delinquent and to prevent suspension of clinical privileges.

   b) When the responsible Attending Physician is unavailable and all efforts to reach the physician have been exhausted, the Chief of Staff or his/her designee will review those medical records and the records will be administratively closed. Records will

not be administratively closed on a routine basis in order to close records resulting from the failure of an Attending Physician to sign his/her documents.

4. All entries in the record will be authenticated by signature, title and date.

   a) Medical records will contain original signed documents and/or electronically authenticated documents. The signature in the electronic record will be electronically time stamped upon completion. In the CPRS, documentation can be edited online prior to authentication with an electronic signature. After a document is signed, all corrections will be done through the use of an addendum.

   b) Medical students may document in the VAMC medical record as a part of their education and training. All medical student entries must be authenticated by the author. Authentication must adhere to the following national VA convention:
      Name, degree (if any)
      Title (e.g. Medical Student)
      All medical student entries must be cosigned by a resident or Attending Physician.

   c) The Chief of Staff approves that Division Managers may designate administrative staff to make administrative entries in the CPRS. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering patient education involving technology, e.g., telehealth (5) entering notes to disposition consultation requests and (6) completing other requirements as requested by the Chief of Staff or his/her designee. HIMC record reviews will include review of administrative entries for appropriateness of documentation.

   d) VistA Imaging administrative display is the alternative location for documentation maintained for administrative purposes only. Administrative aspects involved in the care of a patient, including demographics, eligibility or enrollment, billing, correspondence, and other non-clinical and business-related information are routinely strored in VistA Imaging administrative display, Refer to Station Memorandum MIS-054, *Document Scanning Policy*.

5. Every episode of clinical care will be documented by the respective clinical staff as defined by their scope of practice in a progress note.

   a) Progress notes will be entered into the CPRS by the clinician providing the service to the patient.

   b) Progress notes must be identified with the name and credentials of the individual making the entry.

   c) Progress notes will generally give a pertinent chronological report of the patient's course, changes in condition, response to treatment, interventions, and plans for continuing treatment.

6. Correcting a Note Entered in Error

   a) Entries entered in error may not be deleted from the electronic record, in order to maintain the legal integrity of the record. Procedures should be followed to make the entry non-viewable or unprintable by anyone other than health information personnel or the author.

b) Refer to "How to Correct a Note Written in Error " at the link included below:

[https://vaww.visn12.portal.va.gov/miw/clinicalresource/cprs/CPRS Notes/Correcting Notes Written in Error.doc]

7. Consultations

a) Consultation requests will include reason for the consultation, a brief description of the patient's condition, and other information of value (i.e. medication that may affect the condition being evaluated), and the electronic signature of the requester.
   - Emergency consultations should be requested as a "stat consultation" (see Assessment of Patients PSM II-4) and should be communicated directly from the requesting to the consulting physician, in addition to the electronic request.

b) The consultation report will contain a comprehensive assessment, the clinical recommendations by the consultant, date of the consult, and electronic signature. A consult shall be considered complete when the patient is seen or evaluated by the service or provider that is being consulted and the results of that evaluation are available. Use of the Consult Management package is required.

c) Documentation of resident and fellow supervision should be by separate attending note, addendum to resident note, or co-signature of the resident note. [Refer to VHA Handbook 1400.1 for specific requirements].

d) For inpatient consultations, the clinician will see the patient within 24 hours of the request. [Refer to MCM CIO-146, "Consultation Process and Procedure"].

e) For outpatient consultations, the clinician will render or personally supervise the consultation, meet the patient as soon as possible and stay involved as long as indicated.

8. Orders

a) All orders must contain the date and time the order was written.

b) Order entry for laboratory tests, radiology services, tissue examination, nuclear studies, shall be completed in full; clearly identifying patient location, requester, test date, special handling, and all necessary clinical data as defined by the situation.
   - Reports will reflect a complete record of procedure performed and findings. Electronic signature must authenticate all reports. Computer generated reports will identify the clinician responsible for the interpretation of test results.
   - The appropriate personnel will communicate critical and abnormal findings directly to the responsible clinician.

c) All orders for treatment will be documented appropriately and signed by the practitioner or practitioners responsible for the patient [see Diagnostic & Therapeutic Orders, Automatic Stop Orders & NPO Procedures PSM VII-3]. The responsible clinician will be accountable for the accuracy of the order.
   - Medical students may write orders, provided a supervising physician immediately cosigns the orders.
   - When the automatic stop order policy applies, the clinician should be notified when the drug expires. The clinician will be required to respond

within 24 hours of being notified, or sooner as appropriate for the clinical setting.

d) During business hours, defined as Monday through Friday, excluding Holidays, from 8am to 5pm, verbal and telephone orders are prohibited except in the Intensive Care Unit (ICU), (Operating Room (OR), Post Anesthesia Care Unit (PACU), Ambulatory Procedure Center (APC), Emergency Department (ED), Home Based Primary Care (HBPC), or Cath Lab, or unless one of the criteria below is met.

e) Use of telephone and verbal orders is discouraged, and can only be used in the following situations:

1. Emergency situations when time is of the essence and delaying the order even briefly can cause harm to the patient.
2. During surgery/invasive procedures when it is not feasible for the provider to break sterility to enter an order.
3. The ordering practitioner is not in the house and delaying the order may negatively cause harm to the patient.
4. When a registered pharmacist clarifies a provider's order as a pharmacist intervention. This is done to alert the provider of the order change based upon the pharmacist's intervention.
5. During Home Based Primary Care (HBPC) or Spinal Cord Injury (SCI) Home Care visits, when a delay in changing medication(s) dosage, or prescribed treatment can place the patient at risk or cause harm.

f) Only a registered or graduate nurse, registered pharmacist, registered dietitian, certified or registered respiratory therapist, medical technologist, dietetics technician, licensed practical nurse (GS6), and speech therapists can take a verbal or telephone order.

g) Telephone and verbal orders must be entered into the electronic medical record immediately. All telephone and verbal orders require a verification read-back of the complete order by the person receiving the order. This includes spelling of medications with complicated or sound-alike names. The read back must include correct identification by the patient's complete first and last name. All details of the order including frequencies, doses, start times, etc must be included. The order read back must be documented through the creation of CPRS note titled "Order Read Back". The "Order Read Back" note is templated to assist in its completion. It will also retrieve recent orders by the author and insert them into the body of the note. The authorized provider who issued the verbal or telephonic order must authenticate the order with a written signature on a written order or electronic signature through CPRS as soon as possible within 48 hours for acute care and 96 hours for the Community Living Center (CLC).

h) Text messaging of orders is prohibited. It is not acceptable for physicians or licensed independent practitioners to text orders to the hospital or other healthcare settings.

9. Patient Health Profile Report

a) The Patient Health Profile report contains the Joint Commission required Summary List (IM 6.40) elements including demographics, diagnoses, allergies, medications, adverse drug reactions, and lists of procedures and brief surgery reports for surgeries and procedures.

b) The Patient Health Profile report is available in the patient's electronic medical record. The elements of this Patient Health Profile report are automatically 'pulled in' to the report each time the report is requested. The Patient Health Profile report may be generated 'on demand' by selecting the Patient Inquiry button in the CPRS.

10. Problem List
    a) The Problem List provides clinicians with a current and historical view of the patient's health care problems (ICD-9 diagnoses) across clinical specialties.
    b) The Problem List will be initiated on the first visit to the health care provider.
    c) All providers who see the patient on subsequent visits are responsible for maintaining the Problem List and will review and update problems pertaining to their specialty.
    d) The entire Problem List will be reviewed and updated by the primary care provider on an annual basis.
    e) If the patient does not have a primary care provider at this facility, the specialty providers are responsible for maintaining and updating the Problem List at each visit.

11. Informed Consents

In addition to the informed consent discussion that takes place for any treatment or procedure, the patient's signature Consent (on a VA Consent Form SF-522 (OP-544), Attachment 1) or its electronic equivalent in iMedConsent must be obtained for all diagnostic and therapeutic treatments or procedures as defined in Station Memorandum on Informed Consent, OQM&S-114.

12. History and Physical Examination

a) An acute inpatient admission history and physical (H&P) examination must be performed within 24 hours of admission (including transfers in from another VA facility). For all acute care services the H&P will be comprehensive including chief complaint, history of present illness, complete review of systems (10 or more systems), one item of each: past medical history, family history and social history and general multisystem physical exam of eight or more of twelve systems.

b.) When a patient is re-admitted within a 30-day period, the previous history and physical examination may be used. In this case, an interval note will be entered within 24 hours of admission and will indicate that the previous H&P has been reviewed and will note pertinent changes or lack thereof.

c) If a comprehensive H&P was completed within 30 days of admission care the H&P may utilized upon admission but must be reviewed and updated within 24 hours of admission.

d) History and Physical examinations for 23 hour observation patients will be an expanded problem focused H&P to include: chief complaint, brief history of present illness, problem pertinent review of systems and physical examination limited to affected body organs.

e) All acute H&P's must conclude with a statement of the conclusions or impressions drawn from the history and physical assessment, as well as a statement of the course of action planned for the patient while in the hospital.

f) An H&P that is completed within 30 days of the scheduled surgery or procedure may be utilized, but must be reviewed and updated within 24 hours PRIOR to the surgery.

This may be a comprehensive or problem focused H&P as appropriate to the procedure.

h) History and physical examinations performed and documented by Nurse Practitioners do not require co-signature by a physican.

B. Inpatient Records

1. Elements

a) Each medical record will have at least the following component parts: history and physical examination, progress notes, vital signs, doctor's order, a comprehensive multidisciplinary treatment plan, nursing care documentation and discharge summary. When applicable, the record will include informed consent or documentation of administrative consent, operation reports, pathology reports, Advance Directives, and autopsy findings.

b) Inter-service or Inter-ward Transfer: An inter-service or inter-ward transfer is the formal transfer of an inpatient during an episode of inpatient care from one care unit, clinical service or medical staff member to another. A Transfer Note must be entered into CPRS. The contents of this Transfer Note must contain a concise recapitulation of the hospital course of treatment to the date of the transfer including the indications for transfer, and must be developed in a manner to assist the receiving unit, service, or medical staff member in providing continuity of patient care. The transferring physician must document the transfer note prior to the patient's transfer. The supervising provider is required to co-sign the Transfer Note. If the patient is transferred from one service to another, the accepting Attending Physician should treat the patient as a new admission, which requires an Attending Admission Note or addendum documenting findings and recommendations regarding the treatment plan within 24-hours of admission of transfer, no exceptions for weekends or holidays.

c) An initial treatment plan, documented by the clinician, as part of the physical examination, will be established on all patients within 24 hours of admission on acute medical and psychiatric units. A service treatment plan will be documented by each support service represented on the patient's multidisciplinary team, (e.g., Nutrition, Rehabilitation) as appropriate to the patient's care.

d) Psychiatry programs will formulate comprehensive assessments and treatment plans that indicate a multidisciplinary approach to the patient's care.

e) Special justification and documentation is required for the use of Electro-convulsive and other forms of convulsive therapy. Refer to Electro-convulsive Therapy (ECT) PSM IV-9.

2. Discipline-Specific Documentation

a) There shall be sufficient evidence as documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician.

- The Attending Physician will cosign any inpatient admission history and physical examination, procedure note, consultation, operative report, or discharge summary completed by a medical student or house staff.

- The frequency of attending progress notes shall be determined by the nature of the patient's condition, the likelihood of changes in the treatment plan, the complexity of the care and experience of the trainee being supervised.

b) Nursing Documentation: Refer to Scope of Nursing Assessment & Documentation PSM N-2.
   - Nursing progress notes will document ongoing assessment and reassessment of the patient's condition.

3. Service-Specific Documentation

a) Anesthesiology: See PSM No. IV-10 'Policy on Providing Moderate Sedation / Analgesia in Special Procedure Units Outside the Operating Room Suite Without the Specific Involvement of an Anesthesiologist'.

b) Surgery
   1. Except in emergencies, the attending must write a pre-procedural note or an addendum describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed (may be done up to 30 days pre-op).
   2. A Post-Operative note must be written by the surgeon immediately following surgery and before the patient is transferred to the next level of care.
   3. An operative report will be dictated and signed by the operating surgeon immediately after surgery. It shall contain the indication for the procedure, operative findings, the technical procedure performed, specimens removed, postoperative diagnosis, and the names of the attending surgeon, the primary surgeon, and assistants.
   4. Post-Procedure Anesthesiology Note within 48 hours of surgery/procedure.
      a. For inpatients, at least one documented post-anesthesia visit after patient leaves the Post Anesthesia Care unit indicating the presence or absence of any anesthesia-related complications must be documented.
      b. For outpatients, ambulatory surgery personnel must call the patient after surgery to assess any complications including anesthesia complications as appropriate.

4. Special Issues

a) DNR Orders
   1. An order specifying the patient's code status (either FULL CODE or DNR] is required for all admissions and transfers. Refer to 'Withholding Attempts at Resuscitation: the Do Not Resuscitate or "DNR" Order PSM IV-6'.
   2. Licensed residents (PG-II or above) may, in certain, specified circumstances write DNR orders. DNR orders by the resident must be re-written and the required resident progress note documentation co-signed by the attending physician within 24 hours. [Refer to PSM IV-6 for the specific circumstances and requirements].
   3. Nurse practitioners may, in certain circumstances and as permitted by license, initiate or continue DNR orders in collaboration with the attending physician. Nurse practitioners must document the collaboration in a progress note. The note must be co-signed by the attending physician. [Refer to PSM IV-6 for the specific circumstances and requirements].

b) Advance Directives
   1. The process and documentation requirements for obtaining, reviewing, and implementing an Advanced Directive are stated in Medical Center

Memorandum OQMS-189 Advance Directives for Health Care and Withholding/Withdrawal of Life Sustaining Treatment. There are progress note templates and order sets available to assist in this process. The Social Worker on the team can provide guidance.

2. If a patient has an Advance Directive but the document is not available, the physician will make a note describing the intent of the Advance Directive.

c) Deaths

1. CPRS contains a note entitled "Death Note ". This note title contains a template.
   a. In acute care, the Death Note is to be completed by the physician pronouncing the death.
   b. In the Community Living Center, if the physician is not present to pronounce death, the note may be completed by the Nurse Practitioner or RN who collaborates with the physician in pronouncing the death. See Medical Center Memorandum CLC-15.
   c. In both acute care and CLC, when this note is completed by Residents, Nurse Practitioners, or RNs, the author will be prompted to identify a cosigner.

d) Transfers

1. When a patient is transferred between specialties (e.g., Medicine, Surgery, and Psychiatry), or facilities, a transfer note will be entered into the medical record. The transfer note will give a concise recapitulation of the hospital course to date, include the indications for the transfer, and be co-signed by the attending physician. This note will be documented prior to the patient's transfer. Nursing transfer notes will be documented by the transferring and receiving units and shall note the patient's response to care and status.

e) Discharges

1. Discharge Summaries: Refer to Hospital Discharge Summary PSM III-2. The discharge summary must be dictated prior to the patient's release. A transfer note is acceptable for all patients ASIH (Absent Sick in Hospital) less than 30 days when returning to the Domiciliary or Nursing Home Care Unit). Summaries for deaths or irregular discharges will be documented within 24 hours of the patient's release. An addendum to the Discharge Summary is required when there is a change in the patient's condition prior to discharge.

2. Patients will be discharged only by order of a physician. Any patient leaving against medical advice will have a final progress note written by a physician indicating the reason for leaving and any special disposition arrangements.

f) Autopsies

1. Preliminary or provisional anatomical autopsy diagnoses will be documented within 72 hours. Final protocols will be completed, signed and properly filed within 60 days. Refer to Policies and Indications on Autopsy (Post-Mortem Examination) PSM VI-13.

C. Outpatient Clinic Records

1. A relevant history of the illness or injury and physical findings will be documented in the patient record at a patient's initial visit to VA care on an ambulatory and/or outpatient care level.

2. Each time a patient visits the ambulatory care setting a progress note will be recorded. Documentation shall include an accurate summary of the clinician-patient interactions. This documentation shall include a reason for visit (chief complaint), relevant history and physical findings and a plan. Any procedures performed within the clinic will be documented.

3. An attending physician from each clinic will be responsible for care provided in that clinic.

D. Ambulatory Surgery
Refer to Provision of Care in the Ambulatory Care Center PSM I-4.

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References: VHA Handbook 1907.01 Health Information Management and Health Records, VHA Handbook 1400.1 Resident Supervision. VHA Handbook 1605.2 Minimum Necessary Stadard for Protected Health Information, PSM III-3, OQMS-114, PSM N-2, PSM IV-10, PSM IV-6,OQMS-189, PSM III-2, PSM VI-13, PSM I-4, & PSM IV-9, MIS-054, Joint Commission Comprehensive Accreditation Manuals for Hospitals, Behavioral Health Care, Home Care, and Long Term Care, Current Editions.

Rescissions: PSM III-1 dated 6-2-09
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