

## MANAGEMENT OF INFORMATION

VA PUGET SOUND  
HEALTH CARE SYSTEM

MEMORANDUM IM-30  
NOVEMBER 2013

### SUBJECT: Patient Record Documentation and Completion Requirements

1. **EXECUTIVE SUMMARY:** To define patient record documentation and completion requirements. This revision updates references, procedures, and attachment.
2. **POLICY:**
  - a. **General:**
    - 1) The patient health record consists of the electronic health record and the paper record, combined.
    - 2) Patient records are to contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, justify the treatment, document the course and results accurately, facilitate continuity of care among health care professionals, measure outcomes, support education and research, and facilitate VHA performance improvement processes.
    - 3) Patient records must comply with all regulatory, accrediting and legal requirements, and be timely, relevant, necessary, complete and authenticated. Completeness implies that all required data is present and authenticated, all final diagnoses are recorded without the use of abbreviations, and transcription of any dictated information is completed and inserted and/or uploaded into the record.
    - 4) Documentation in the medical record must support the CPT and ICD-9-CM or ICD-10-CM codes for workload and billing purposes.
  - b. **Requirement to Document:** The health care practitioner that treats the patient, as defined by their privileges or scope of practice, is responsible for documenting and authenticating the care provided. Health care practitioners involved with the patient's care must document every episode of care.
  - c. **Computer Competency:** All clinical staff authorized to document in a health record must record the care in the Computerized Patient Record System (CPRS), except in those instances where technology is not available for electronic entry. Clinicians active in patient care must be competent in using the facility's computer systems. Competency is defined as the ability to use the facility's computer system for electronic mail, viewing, ordering, and documenting patient care in CPRS. Responsibility for ensuring competency resides with each service line leader.

- d. Responsibility for Documentation of Care:** The supervising practitioner (i.e., a licensed independent practitioner that is credentialed and privileged at VA Puget Sound) is responsible to ensure a complete medical record for each patient with accurate, complete and timely entries that describe care provided by or supervised by him or her. Care provided to each patient is individualized and determined based upon the patient's needs. This determination is based on an assessment of the patient's relevant physical, psychological, and social status needs. Dentists are responsible for completion of the dental aspects of the medical record. Service Lines are responsible for monitoring compliance with documentation requirements.
- e. Timeliness:** Health record entries must be completed, processed promptly, signed and/or co-signed as necessary, and transmitted, filed, and/or uploaded in accordance with defined timeframes to ensure the information is available for patient care.
- f. Evaluation and Management (E&M) Services:** The accurate documentation of care provided in each of the three E&M components determines the level of E&M services provided. This has a direct impact on workload, costing, and reimbursement for VA Puget Sound. For E&M services, the nature and amount of clinician work and documentation varies by the type of service, place of service, and the patient's status. The three components of an E&M service, which are considered or validated to determine the appropriate level of the E&M service, are history, examination, and medical decision-making. Health Information Management Section (HIMS) is the subject matter expert resource for the medical center for selection of appropriate CPT/E&M codes.
- g. Confidentiality and Security:** Authorized users of the health record are responsible for ensuring that patient information is kept confidential and is not disclosed to unauthorized individuals or groups, and for ensuring information security by protecting and not sharing individual user access and verify codes, passwords, or electronic signature codes.
- h. Authentication:**

  - 1) General:** Authentication means to establish authorship by written or electronic signature. Electronic signatures on medical documents are treated as written signatures with all of the ethical and legal implications thereof. The author is legally responsible for any actions occurring under his/her access and verify codes and/or electronic signature. Authors of orders, notes, consults, and other medical record documentation are responsible for authenticating the documents. Only authorized individuals may make entries into medical records (see Policy IM-03, Attachment A, "Individuals Authorized to Write Notes in the Health Record"). Authentication must include the identity

and credential and/or professional discipline of the author. If the title block is used, it needs to accurately reflect the functional position of the user as defined by the service line.

**2) CPRS Access and Signature:** Authorized individuals are granted appropriate computer menus, keys, and individual access and verify codes in order to make medical record entries. Every entry into CPRS is to be authenticated (signed) by the author at the conclusion of each entry using his/her electronic signature code.

**3) Paper Documents:** Every entry onto a paper medical record document is to be authenticated by the author at the conclusion of each entry by written signature. The use of rubber stamps in lieu of a written or electronic signature is prohibited.

- i. **Copying and Pasting:** Importing text from other CPRS sources is a powerful tool. This functionality, however, must be used judiciously. Copying and pasting makes records longer without adding new information, can expose the author to legal risks, and can propagate information errors. Copied information should be brief, selective, specific, and pertinent to the care that is being provided during the current visit. If information is copied, the original source (person and date) must be cited and quotation marks placed around the information that was copied. Authors are responsible and accountable for information in their authenticated (signed) notes, including information that was copied and pasted from the work of others.
- j. **Abbreviations and Symbols:** Only symbols and abbreviations listed in an approved medical dictionary will be used in the patient records. A dictionary is available on the computer (pathway: VA Puget Sound Home Page, Quick Links, Clinicians [Home Page], StatRef, Taber's [search], Resources). Abbreviations found in this reference CANNOT be used for those that have been designated as "unapproved" (see Policy IM-03, Attachment B, "Unapproved Abbreviations and Symbols for Health Record Entries"). NO abbreviations are to be used in Discharge Summaries.
- k. **Medical Students:** All students are expected to learn to fully document in progress notes the care/treatment provided as part of their educational experience. Students are not licensed providers and cannot be assigned a person class. Therefore, they are not classified as a "provider". Students may only document as scribes and must change authorship to the supervising clinician after a note is written. The supervising clinician is responsible and accountable for the content of the note. (See Policy IM-03, "Health Information Management and Health Records, Attachment A, "Individuals Authorized to Write Notes in the Health Record".)

### **3. PROCEDURES:**

#### **a. Basic Patient Medical Record Requirements:**

- 1) Patient identification,
- 2) Medical history (including history of present illness/injury) and physical examination,
- 3) Observations, including results of therapy,
- 4) Diagnostic and therapeutic orders,
- 5) Report of procedures, tests, and results,
- 6) Progress notes,
- 7) Consultation reports,
- 8) Conclusions at termination of hospitalization, or evaluation treatment,
- 9) Informed consent before procedures or treatments are undertaken and if not obtainable, the reason, and
- 10) Allergy information.

#### **b. Inpatient Documentation Requirements:**

- 1) Admission History and Physical Examination: (See Attachment A)
  - a) History and Physical (H&P) examinations will be performed, documented and authenticated by the author within 24 hours of admission, including weekends and holidays (within 72 hours for Extended Care; within one week for Mental Health residential care, e.g., Domiciliary). Once signed electronically in CPRS by the author, the H&P is viewable by all CPRS users.
  - b) The history is to include the chief complaint, present/past illnesses, personal/social/family histories, and complete review of systems. All positive and pertinent negative findings must be individually documented. The physical exam is to contain the result of a complete physical examination and findings from an assessment of all body systems examined.

- c) History and Physical examinations by Residents or Physician Assistants are to be co-signed by the Attending supervising physician (signifying review and concurrence with the content), or reviewed with an indication of acceptance or correction by the Attending in a separate Attending note or in an addendum to the Resident or Physician Assistant's note. The Attending's co-signature, separate note, or addendum must be completed and signed within 24 hours after admission (within 72 hours for Extended Care; within one week for MH residential care, e.g., Domiciliary).
- d) History and Physical examinations by Advanced Practice Nurses (APN) are to be co-signed by the Attending physician within 24 hours of admission if co-signature is required in the scope of practice or clinical privileges for the individual APN.
- e) Updates to H&P's Completed Up to 30 Days Prior to Scheduled Admission or Surgery:
  - (1) The H&P may be completed up to 30 days prior to a scheduled admission provided that the Attending sees and examines the patient and records an update to the patient's condition within 24 hours of admission that documents the following:
    - (a) The H&P is still accurate and the patient's condition has not changed since the H&P was originally completed, or changes are documented, and
    - (b) An appropriate assessment was completed on admission confirming that the necessity for the procedure or care is still present.
  - (2) The H&P may be completed up to 30 days prior to surgery provided that the Attending sees and examines the patient and records an update to the patient's condition the day of surgery that documents the following:
    - (a) The H&P is still accurate and the patient's condition has not changed since the H&P was originally completed, or changes are documented, and
    - (b) An appropriate assessment was completed prior to surgery confirming that the necessity for the procedure is still present.

## **2) Attending Admission Note:**

- a) For inpatient admissions, and transfers into the Intensive Care Units (Medical, Cardiac, and Surgical ICUs), the Attending physician is to physically meet, examine, and evaluate the patient and document when s/he examined the patient, the findings, and summarize the assessment and plan within 24 hours of admission (within 72 hours of admission for Extended Care patients). If a Resident or Physician Assistant was involved, the Attending's note may be a separate note, or an addendum to the Resident or Physician Assistant's note. The Attending's note must document any concurrence or disagreement with a Resident or Physician Assistant's diagnosis and treatment plan and indicate any modifications or additions.
- b) Attending Admission Note in Lieu of Pre-operative or Pre-procedure Note. For scheduled surgery or other procedure that places the patient at risk and/or involves the use of sedation or anesthesia, pre-operative or pre-procedure assessments that include the diagnosis, indications for treatment, patient's suitability for treatment, and risks may be part of the Attending's admission note in lieu of a separate pre-operative or pre-procedure note if it is written within one calendar day of admission.

## **3) Inpatient Progress Notes:**

- a) Inpatient progress notes will be written and signed at the time of observation, at a frequency appropriate to the patient's condition, and in sufficient detail to permit continuity of care and transferability.
- b) Notes will be written at least daily for critically ill patients, for those whose work-up is still in progress to establish a diagnosis, or where there is difficulty in the management of clinical problems.
- c) Notes by residents will contain evidence of attending supervision in accordance with VHA Handbook 1400.1, "Resident Supervision" and VA Puget Sound policy.
- d) Inpatient Transfer Note: The Attending, in consultation with an involved resident, is to ensure that the transfer of a patient to another service, treating specialty, different level of care, or VA facility is appropriate and based on the patient's diagnosis and therapeutic regimen. The Attending on the receiving service must treat the patient as a new admission and write an independent note or an addendum to the resident's transfer acceptance note. Factors addressed may include physical activity, medications, diet, functional status, and follow-up plans.

**4) Discharge Note:**

- a) A patient death while admitted is considered a discharge and requires that all discharge documentation be completed.
- b) The final diagnoses are to be recorded in full in both the discharge note and the discharge summary without the use of symbols or abbreviations. The principal diagnosis is to be listed as the first diagnosis in the Discharge Note. The principal diagnosis is that condition which, after study, occasioned the admission to the hospital. If the discharge summary is completed and authenticated prior to the time of discharge, and contains all the elements of the discharge note, including evidence of medication reconciliation and patient education, the Discharge Summary will meet the need for a discharge progress note.
- c) A discharge progress note must be directly entered into CPRS before discharge. The discharge note must contain all of the following:
  - (1) Date of admission,
  - (2) Date of discharge,
  - (3) Type of discharge (regular, irregular, transfer out or death),
  - (4) Diagnoses,
  - (5) Brief description of hospitalization,
  - (6) Discharge medications,
  - (7) Evidence of medication reconciliation,
  - (8) Recommendations relevant to diet, exercise, limitations of activity, condition on discharge (to include character of surgical wound, if appropriate),
  - (9) Place of disposition; e.g., to home, contract nursing home, outside facility, etc.,
  - (10) Recommendations for follow-up and patient education, and
  - (11) In cases of death, the date and time of death and the events leading to the death must be documented.

**5) Discharge Summary:**

- a) A discharge summary needs to be prepared for all releases from VHA care, including deaths. Transfers to other levels of care, i.e., VHA domiciliary care, VHA nursing home, or other VHA medical centers, must be documented by a discharge summary. The treating specialty from which the patient is discharged is responsible for completing the summary.
- b) Timeframes for completion: A discharge summary is to be created (dictated or direct entry into CPRS) and signed by the Attending at the time of discharge, no earlier than 48 hours prior to discharge, and no later than 3 calendar days after discharge. However, in the case of a patient transferring to another treatment facility, the Attending is to ensure that the discharge summary is completed and signed before the patient leaves VA Puget Sound. In the case of death or irregular discharge, the discharge summary is to be completed and signed within 24 hours.
- c) If not the author, the Attending with primary responsibility for the patient must review the summary, make appropriate edits, and indicate approval with his/her co-signature.
- d) General documentation requirements:
  - (1) Diagnoses: State in full without symbols or abbreviations, in accordance with current International Classification of Disease (ICD), to include:
    - (a) Principal diagnosis responsible for hospital admission listed first, then all other diagnoses for which treatment was given, in the order of clinical importance,
    - (b) Post-operative complications or infections,
    - (c) Drug or serum reactions, and
    - (d) Site and etiology of the diagnoses.
  - (2) Psychiatric Diagnoses: State in accordance with current Diagnostic and Statistical Manual of Mental Disorders (DSM).
  - (3) Operations and Surgical Procedures: State in full without symbols or abbreviations, in accordance with current CPT and/or ICD Procedural Index), including:
    - (a) Site involved and procedures performed,

- (b) All operations, diagnostic and therapeutic procedures, and the date performed, and
- (c) All procedures need to be documented in the text of the summary.
- (4) Discharge Summary content requirements:
  - (a) Name of Attending and primary physician, if applicable,
  - (b) Reason for admission (principle diagnosis),
  - (c) Other diagnoses and /or conditions treated,
  - (d) All operations and procedures performed and the treatment provided during current admission, with dates,
  - (e) Medical history and pertinent findings,
  - (f) Physical examination with pertinent findings, particularly abnormalities,
  - (g) Allergies and drug sensitivities,
  - (h) Laboratory and radiological pertinent findings,
  - (i) Mental status (required for mental health),
  - (j) Hospital course of stay to include treatment received and condition on discharge (specific and measurable in comparison with condition on admission),
  - (k) Wound condition, if applicable,
  - (l) Place of disposition, i.e., home, nursing home, etc.,
  - (m) Discharge instructions to patient, or responsible other, to include:
    - i. Patient's condition and proper home care, if applicable,
    - ii. Medical follow-up, If by private physician, state name if possible,
    - iii. Medications on discharge,
    - iv. Diet instructions,

- v. Activity and/or limitations, and
  - vi. Specific date to return to work. State if retired; otherwise, state if a period of convalescence is required and if a return to work date is to be determined at a later date.
- (n) Competency (statement required if patient has a psychosis or organic mental impairment), and
- (o) .For death cases, statement that an autopsy was or was not performed.

6) Completion of Inpatient Medical Records:

- a) Medical staff members and others entering data in the medical record are to fulfill all appropriate actions to complete the medical record documentation in accordance with required timeframes.
- b) A discharge inpatient medical record is considered complete when both the discharge summary and operative report, if required, are present and signed/co-signed. Other medical record documentation will be reviewed periodically and feedback provided to the clinical staff, as appropriate.
- c) Delinquent Inpatient Medical Records: Records are considered delinquent if incomplete 30 days after discharge. Suspension of clinical privileges for the Attending of record may be pursued.

c. **Outpatient Documentation Requirements.**

1) Outpatient Progress Notes:

- a) Outpatient progress notes will be individually documented and signed in CPRS at the time of each encounter,
- b) The notes will contain:
  - (1) Presenting problem(s) (reason for visit),
  - (2) History, including allergies and immunization status,
  - (3) Objective data relevant to the presenting problem(s),
  - (4) Assessment of the problem(s),

- (5) Treatment plan for the problem(s),
  - (6) Primary and secondary diagnoses treated during an encounter or that requires further treatment,
  - (7) The medical basis for ordering tests, consults and/or changes in medications and the expected length of duration, and
  - (8) Follow-up treatment and patient instructions.
- c) A historical note will be completed on the occasion of broken appointments or termination of treatment.
  - d) Patients new to the facility or new to a clinic. At the initial visit, patients that are seen by a resident must be seen by or discussed with the Attending responsible for the clinic. This must be documented by the Attending in a separate note, as an addendum to the resident's note, or reflected in the resident's note that includes the name of the supervising practitioner and a summary of the discussion.
  - e) Return patients are to be seen by or discussed with the Attending at a frequency that ensures an effective and appropriate course of treatment. The identity of the Attending and supervision of the resident must be evident for each resident's patient care encounter (i.e., by a separate Attending's note), the Attending's addendum to the resident's note, the Attending's co-signature of the resident's note, or reflected in the resident's note that includes the name of the Attending and a summary of the discussion with the Attending.
  - f) Documentation of initial and return visit is to be completed and authenticated no later than seven (7) calendar days after the visit.
- 2) Outpatient Clinic Discharge Note.
- a) The Attending, in consultation with an involved resident, ensures that the discharge of a patient from a clinic is documented, is appropriate, and is based on the patient's diagnosis and therapeutic regimen. Factors addressed may include physical activity, medications, diet, functional status, and follow-up plans.
  - b) Outpatient clinic discharge notes may be a separate Attending's note, an Attending's addendum to the resident's note, the Attending's co-signature of the resident's note, or a resident's note that includes the name of the Attending and a summary of the discussion with the Attending.

3) Emergency and Urgent Care:

- a) Documentation for patients presenting to the emergency or urgent care areas for treatment is to be recorded in CPRS (direct entry or dictated) as soon as possible and signed within 24 hours of the patient's departure, or within 4 hours for patients being admitted.
- b) Documentation is to include the following:
  - (1) Time and means of arrival,
  - (2) Presenting problems, i.e., the reason for visit,
  - (3) History and objective data relevant to the presenting problem,
  - (4) Assessment of the problem,
  - (5) Treatment plan for the problem,
  - (6) Primary and secondary diagnoses dealt with at this encounter,
  - (7) Reasons for ordering diagnostic tests, consult or changes in medication,
  - (8) Care received prior to arrival,
  - (9) Condition at discharge, and
  - (10) Discharge instructions.
- c) If patient left against medical advice:
  - (1) When a patient leaves after triage by nursing staff and before examination by a licensed independent practitioner (LIP), an LIP must review the triage documentation and determine whether an emergency existed, and contact the patient when an intervention must be made to protect the patient.
  - (2) The triage note must be added to the documentation that states that the patient left.
- d) Emergency Care additional requirements:
  - (1) Documentation in a patient record of any emergency care rendered for humanitarian reasons to a person who is not admitted.

- (2) Providing a copy of the record of emergency services to the practitioner or medical organization responsible for follow-up care.
- e) Emergency Transfers: Documentation on emergency patient transfers to other organizations must include:
  - (1) Reason for the transfer,
  - (2) Stability of the patient,
  - (3) Acceptance by the receiving organization, and
  - (4) Responsibility during transfer.

**d. Clinical Consult Reports:**

- 1) Attendings are to perform clinical consults or personally supervise clinical consults performed by residents. Documentation of resident supervision can be contained in an Attending's consult report; the Attending's addendum to the resident's consult report; the Attending's co-signature of the resident's consult report; or the resident's consult report that includes the name of the Attending with whom the case was discussed, a summary of the discussion, and the Attending's assessment of the diagnosis and/or plan for evaluation and/or treatment.
- 2) Inpatient clinical consults that require the consulting clinician to see the patient are to be recorded (dictated or direct computer entry), signed and closed in CPRS in accordance with the urgency of the situation (e.g., 24 hours for acute patients), but no later than three (3) calendar days after the patient is seen.
- 3) Outpatient clinical consults that require the consulting clinician to see the patient are to be recorded (dictated or direct computer entry), signed, and closed in CPRS as soon as possible after the visit.
  - a) Urgent consult requests are to be completed, signed, and available to the requesting party within 24 hours of the patient being seen, and no longer than 72 hours of the consult request.
  - b) Routine consult requests are to be completed, signed, and available to the requesting party as soon as possible, but no longer than seven (7) calendar days of the patient being seen.

- c) Non-visit consults are to be recorded (dictated or direct computer entry), signed and closed in CPRS as soon as possible after review, but no longer than seven (7) calendar days after the request.

**e. Surgical Procedure Requirements:**

- 1) General: All aspects of a surgical patient's care, including ambulatory surgery, preoperative, operative, and postoperative care must be documented in the patient record, including:

- a) Preoperative diagnoses,
- b) Complete description of the surgical procedure and findings,
- c) Names of all practitioners involved in the patient's care,
- d) Post-operative course,
- e) Evidence of the patient's readiness for discharge from post-anesthesia care, and
- f) Details of the discharge.

- 2) Pre-Operative Note:

- a) Prior to OR and same day (ambulatory) surgical procedures, including invasive procedures using sedation/analgesia or anesthesia, the Attending is to evaluate the patient and document:
  - (1) History and physical,
  - (2) Findings of the evaluation,
  - (3) Test results,
  - (4) Provisional pre-operative diagnoses,
  - (5) Patient's suitability,
  - (6) Treatment plan and/or choice of specific procedure to be performed,
  - (7) Discussion with the patient and family about risks, benefits, potential complications, and
  - (8) Alternatives to planned surgery.

- b) For all elective or scheduled surgical procedures and in cases of emergency surgery (if circumstances permit), the Attending must evaluate the patient and write a separate pre-operative note or an addendum to the resident's pre-operative note.
  - c) A pre-operative evaluation and note may be done up to 30 days in advance of the surgical procedure provided that the Attending sees and examines the patient and records an update to the patient's condition on the day of surgery that documents the following:
    - (1) The H&P is still accurate and the patient's condition has not changed since the H&P was originally completed, or changes are documented, and
    - (2) An appropriate assessment was completed on admission confirming that the necessity for the procedure or care is still present.
  - d) A pre-operative note may serve as the Attending's admission note if it is written within one (1) calendar day of admission by the Attending with responsibility for continuing care of the inpatient, and the note meets criteria for both admission and pre-operative notes.
  - e) Immediately before sedation or anesthesia induction begins, there must be an immediate pre-operative re-evaluation by the Attending surgeon to verify and document the patient's condition. The requirement for this note does not apply in emergencies where any delay would constitute a hazard to the patient.
- 3) Pre-Operative Anesthetic Assessments and Plans:
- a) Prior to a surgical procedure, including invasive procedures using sedation/analgesia or anesthesia, a pre-anesthesia history and physical examination is to be conducted and documented, and a plan developed.
  - b) Pre-anesthesia notes will document pertinent information relevant to the choice of anesthesia, surgical procedure anticipated, previous drug history, and other anesthetic problems. The pre-anesthetic assessment should include a risk assessment for which any generally accepted classification system can be used.
  - c) Pre-operative Anesthetic Assessments and Plans by residents for Level 3-Deep sedation/analgesia and Level 4-Anesthesia are to be reviewed by the Attending Anesthesiologist.

- d) The Attending Anesthesiologist is to meet with the patient and document the review of the assessment and plan on the anesthesia record in CPRS.
  - e) Immediate pre-induction assessments are to be documented by the Attending Anesthesiologist on the anesthesia record in CPRS.
- 4) Informed Consent: Unless otherwise provided in facility policy, all treatments and procedures require the prior, voluntary informed consent of the patient; or if the patient lacks decision-making capacity, the patient's authorized surrogate. The patient's signed consent must be obtained no more than 60 days prior to the procedure or treatment. A valid informed consent must include the signatures of the patient and the performing clinician, as well as the date and time signed. (See Policy RI-06, *Informed Consent for Clinical Treatments and Procedures*).
- 5) Intra-operative Documentation: During the procedure, the patient's physiological status is measured, assessed and documented.
- 6) Post-Operative Documentation:
- a) Immediate Brief Post-Operative Note:
    - (1) In order to provide pertinent information to staff caring for the patient, a post-operative note must be entered into the medical record by the surgeon immediately after each surgery and before the patient is transferred to the next level of care [e.g., to Post-Anesthesia Recovery Unit (PARU)].
    - (2) As appropriate for the surgical procedure, the immediate brief post-operative note must include:
      - (a) Pre-operative diagnosis,
      - (b) Post-operative diagnosis,
      - (c) Technical procedures used,
      - (d) Names of surgeons,
      - (e) Findings,
      - (f) Specimens removed,
      - (g) Complications,

- (h) Anesthesia,
- (i) Blood loss,
- (j) Drains,
- (k) Tourniquet Time, and
- (l) Plan.

(3) Notes by residents are to include the name of the Attending involved in the case and the nature of the Attending's involvement.

b) Operative Report:

(1) Operative reports should be dictated immediately after surgery, but no later than 12 hours after surgery. The Operative Report is to be electronically signed by the Attending within seven (7) calendar days after surgery.

(2) Operative reports are to include:

- (a) Primary surgeon's name,
- (b) Supervising practitioner's name,
- (c) Presence and/or involvement of the supervising practitioner,
- (d) Surgeons and Assistants' names,
- (e) Patient name and Social Security number,
- (f) Date of operation/procedure,
- (g) Case number,
- (h) Pre-operative diagnosis (indication for the procedure),
- (i) Post-operative diagnosis,
- (j) Operation performed (including any intra-operative complications),
- (k) Estimated blood loss,
- (l) Specimens removed,

- (m) Indications,
- (n) Operative findings, and
- (o) Technical procedure used.

c) The Recovery Room Note must document:

- (1) Vital signs,
- (2) Level of consciousness,
- (3) Medications,
- (4) Blood and blood components,
- (5) Unusual events,
- (6) Post-operative complications, including blood transfusion reactions,  
and
- (7) Management of unusual events or post-operative complications.

d) Post-Operative Progress Notes: Notes for routine post-operative follow-up visits, e.g., suture removal, do not require evidence of attending supervision. However, a major change in the patient's condition (positive or negative) does need to be documented with evidence of Attending supervision, i.e., separate Attending note, Attending's addendum to the resident's note, Attending's co-signature of the resident's note, or the resident's note that includes the name of the Attending and a summary of the discussion with the Attending.

f. **Non-Surgical Procedures:**

1) Pre-Procedure Note:

- a) For elective or scheduled diagnostic or therapeutic procedures requiring the explicit approval of the Attending, e.g., procedures performed in the operating suite, angiograms, endoscopy, bronchoscopy, and other procedures requiring signature informed consent (see Policy RI-6, *Informed Consent for Clinical Treatments and Procedures*), the Attending is to evaluate the patient and document the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be performed. The

documentation may be as a separate Attending note or the Attending's addendum to the resident's note.

- b) A pre-procedure evaluation and note may be done up to 30 days in advance of the diagnostic or therapeutic procedure provided that the Attending sees and examines the patient and records an update to the patient's condition on the day of the procedure that documents the following:
    - (1) The H&P is still accurate and the patient's condition has not changed since the H&P was originally completed, or changes are documented, and
    - (2) An appropriate assessment was completed confirming that the necessity for the procedure is still present.
  - c) A pre-procedure note may serve as the Attending's admission note if it is written within one (1) calendar day of admission by the Attending with responsibility for continuing care of the inpatient, and the note meets criteria for both admission and pre-procedure notes.
  - d) The pre-procedure evaluation note requirement by the supervising practitioner does not apply to routine bedside procedures and clinic procedures such as skin biopsy, central and peripheral lines, lumbar punctures, centeses, incision and drainage, etc.
- 2) Informed Consent: Unless otherwise provided in facility policy, all treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, the patient's authorized surrogate. The patient's signed consent must be obtained no more than 60 days prior to the procedure or treatment. A valid informed consent must include the signatures of the patient and the performing clinician, as well as the date and time signed. (See Policy RI-06, *Informed Consent for Clinical Treatments and Procedures*).
- 3) Emergency Procedure Note:
- a) In an emergency situation, where immediate care involving a diagnostic or therapeutic procedure with significant risk is necessary to preserve the life or to prevent serious impairment of the health of a patient, a resident is required to consult with the supervising practitioner to obtain approval and authorization to proceed, and determine who will be available to assist or to advise, as appropriate.
  - b) The resident's note must document:

- (1) The resident's discussion with the Attending, by name, and
  - (2) Details of the case and the proposed procedure.
- c) If the patient is unable to consent, and the patient has no surrogate or the clinician determines that waiting to obtain consent from the surrogate would increase the hazard to the patient's life or health, the patient's consent is implied by law. (See Policy RI-06, *Informed Consent for Clinical Treatments and Procedures*) for documentation requirements regarding consent.

**g. Orders:**

- 1) All orders must contain the date, time the order was written, and the name of the practitioner placing the order. They must be signed and correspond to the individual's clinical privileges or scope of practice.
- 2) Applicable diagnostic information to justify the service ordered must be documented in the patient record.
- 3) Per Policy TX-28, *Ordering Procedures Using the Computerized Patient Record System (CPRS)*, all consultative, diagnostic, and treatment orders are to be entered into CPRS with the following exceptions for orders on paper:
  - a) Bone Marrow Treatment,
  - b) Chemotherapy,
  - c) Post-Anesthesia Recovery Unit orders that will be carried out during the PARU stay, and
  - d) Orders in or for the Operating Room and other designated procedural areas.

- h. **Advance Directives:** When a patient completes or updates an Advance Directive, the document is to be scanned into the patient's record by Health Information Management Section (HIMS). (See Policy RI-03, *Advance Directives for Health Care*).

**i. Autopsy Reports:**

- 1) Preliminary or provisional anatomical diagnoses must be documented within 72 hours of autopsy.

- 2) Final protocols must be completed, signed, and properly filed within 30 days of autopsy.
- 3) The Death Certificate must be amended when the results of an autopsy require a change in cause of death.

j. **Organ/Tissue Donation or Transplants:**

- 1) Documentation requirements regarding organ/tissue procurements are contained in Policy RI-04, *Organ/Tissue Procurement Program*.
- 2) Documentation requirements regarding marrow transplants are contained in Policy CC-02, *Marrow Transplant Program*.

- k. **Allergies:** Allergy or adverse reaction information is entered into CPRS through the Orders tab. A CWAD note is automatically created resulting in the “A” for Allergy on the “Posting” button in the patient’s electronic medical record.

- l. **Patient Problem List (Summary List):** The problem list is maintained for all patients in CPRS. It is the responsibility of the primary care provider to maintain and update each patient’s problem list to ensure accurate, relevant information. The list may include chronic medical conditions and applicable post-surgical statuses. Transient problems, symptoms or undiagnosed new problems are not ordinarily added to the problem list. When a final diagnosis is a new problem, the clinician determines whether to add it to the problem list. Problems may be added directly by the provider or by a clerk at the direction of the provider.

4. **RESPONSIBILITIES:**

- a. The **Chief of Staff**, or designee, has oversight responsibility for health record timeliness, accuracy, and completion.
- b. The **supervising practitioner**, (i.e., Attending physician) is ultimately responsible for the content, quality, timeliness, completion, and authentication of documentation for each patient under their care.
- c. The **author of the entry** is responsible for documenting, completing, authenticating, and correcting any health record deficiencies within established time frames.
- d. **Service lines** are responsible for educating and monitoring compliance with documentation standards for assigned clinical staff. As required, reports will be submitted to the appropriate CPRS oversight committee (Clinical Informatics Steering Committee or the CPRS Clinical Services Document Review Committee) or the Clinical Executive Board.

- e. **Health Information Management Section (HIMS)** is responsible for medical record review activities in order to measure facility compliance with documentation standards. As required, reports will be submitted to the CPRS Clinical Services Document Review Committee and/or the Clinical Executive Board.

**5. REFERENCES:**

- a. Comprehensive Accreditation Manual of Hospital, Behavioral Health, Home Care, and Nursing and Rehabilitation Services, January 1, 2013 (updated July 1, 2013).
- b. VHA Handbook 1907.01, Health Information Management and Health Records, September 19, 2012.
- c. VHA Handbook 1400.01, Resident Supervision, December 19, 2012.

**6. RESCISSIONS:** Policy IM-30, October 2007.

**7. FOLLOW-UP RESPONSIBILITY:** Director, Clinical & Health Informatics.

**8. EXPIRATION:** Last work day of October 2016.

**MICHAEL J. MURPHY, FACHE**

Director

Attachment A: H&P Chart

### H & P Done by an Attending Physician or ARNP

IF the H&P is done	Attending/ARNP	THEN
<b>Up to 30 days prior to admission</b>	Documents and authenticates the H&P within 30 days prior to admission	Examines patient and documents any changes in status within 24 hours of admission (on same day for surgeries and procedures requiring signature consent)
<b>At the time of admission</b>	documents and authenticates the H&P within 30 days prior to admission	Examines patient and documents any changes in status within 24 hours of admission (on same day for surgeries and procedures requiring signature consent)

### H & P Done by a Resident or Physician Assistant

IF the H&P is Done	Resident/PA	Then the Resident/PA	Attending	And the Attending
<b>Up to 30 days prior to admission</b>	Documents and authenticates the H&P within 30 days prior to admission	Examines patient and documents any changes in status within 24 hours of admission (on same day for surgeries and procedures requiring signature consent)	Attending either co-signs H&P or writes an independent note or addendum accepting the H&P and noting any disagreement within 24 hours of admission (72 hrs. Ext. Care, one week MH residential care).	Must meet and examine patient within 24 hours of admission and a documented admission note (72 hrs. Ext. Care)
<b>At the time of admission</b>	Examines patient, documents and authenticates the H&P within 24 hours of admission (72 hrs. Ext. Care, one week MH residential care)	N/A		