Department of Veterans Affairs
VA Pittsburgh Healthcare System
Pittsburgh, PA 15240

MEMORANDUM IM-013

March 5, 2015

CHARTING GUIDELINES

I. PURPOSE

To establish policy and procedures for the initiation, completion and maintenance of medical records, as well as documentation and time standards.

II. POLICY

It is the policy of the Department of Veterans Affairs to maintain complete, accurate, relevant and timely medical records, which contain sufficient information to serve as a basis for planning and documenting patient care, support the diagnosis and warrant the treatment and outcomes, and provide for continuity in the evaluation of the patient's condition and treatment.

III. PROCEDURE

A. General guidelines

1. Medical records will be complete, concise, legible and accurate documents relating to the chief complaint, past medical history, social history, history of present illness, physical examination on admission and provisional diagnoses, statement of treatment planned, clinical laboratory, pathology and x-ray findings, documentation of informed consent, description of operations performed, adequate progress notes including evidence of discharge planning, consultations and other special reports, diagnostic and therapeutic orders, final diagnoses, condition on release, competence opinion for psychiatric patients, follow-up recommendations and instructions and an appropriate summary. Entries in the medical record will be made only by individuals authorized as specified in VA directives and facility policy as recommended by the medical staff bylaws. Opinions requiring medical judgment should be documented or authenticated only by medical staff members and other individuals who have been granted such clinical privilege.

2. Electronic documentation via the Computerized Patient Record System (CPRS) will be authenticated (electronically signed) as soon as possible after the preparation or completion of the entry. The signature block will contain the full name and title of the practitioner making the entry. When CPRS is not available, entry should be as per service line contingency plans. When electronic entry into CPRS is not available, approved paper medical record forms may be utilized. Entries on paper forms must use black ink, english language, and legible in narrative form without skipping lines. Paper documents will be scanned in per service line contingency plans.

3. Information contained in the medical record must be accurate.

a. Hardcopy corrections: If any entry or a portion of any entry is found to be incorrect, a single line will be drawn through the incorrect information without obliterating the original entry, with the word "error" written, initials and date of the correction. The correct information will be added, if appropriate; the notation will be signed and dated by the person who documented the inappropriate or erroneous entry. If a supplemental or corrective statement is needed, it should be entered in the record chronologically by date of the entry. The supplement/correction should indicate the entry to which it has reference.

b. Electronic corrections

(1) Clinicians making an error should immediately contact the supervisor or designee, Health Information Management Service (HIMS).

(2) When a progress note error is made such that the information placed on the chart is incorrect, incomplete, or has already been placed into the correct chart, the clinician should once again contact the supervisor or designee, HIMS and add an addendum to the incorrect entry indicating that it is an error. The supervisor or designee, HIMS will then change the title of the note to "Erroneous Note". Notes with this title cannot be viewed or printed except by approved personnel.

4. Abbreviations may be used in the medical record as noted in Memorandum IM-003 Abbreviations. Symbols and abbreviations will not be used when documenting final diagnoses, complications, and operative procedures on the hospital summary.

5. Reports of Special Incidents – Copies of investigations concerning patients will not be filed in the medical record. The circumstances of an incident involving a patient will be documented thoroughly in the progress notes by the individual responsible for reporting the incident.

6. Only prescribed standard forms, Central Office approved VA forms, templates or form letters, clinical informatics / forms committee approved local templates or paper forms, or computer-generated forms will be used. **Attachment A** describes the process for approval of a locally approved CPRS Template or paper form.

7. Initialed entries on approved paper forms will be substantiated by at least one entry with the signature and name of the individual making initialed entry. Note that initials are not possible in CPRS and co-signatures are not possible with electronic orders.

8. Each page of any paper document must include patient information (full name and second unique identifier; when possible last 4 digits of the Social Security number (SSN) are used instead of full SSN). Documentation continued on a second page will include page numbers (i.e. page 1 of 2, page 2 of 2). Unit secretaries are responsible for properly labeling of any inpatient paper documents prior to sending the discharge material to HIMS chart processing. Clinical staff and clerical clinic staff is responsible for proper labeling of any paper documents sent for scanning.

9. If unusual circumstances prevent proper completion, the health record must be referred to computer and information technology (CIT) for review. If CIT concurs with declaring the record complete for filing purposes, the HIMS Program manager or HIMS designee will complete an administrative note detailing the portion(s) known to be incomplete, and the reason(s) normal completion could not be accomplished.

B. Specific documentation

1. Vital signs including numerical rating score for pain will be documented electronically via the vital sign package or on approved paper forms.

2. Consultation requests will be entered electronically in the Computerized Patient Recording System (CPRS). Consultation results should contain the following information in a concise and complete format:

a. Brief description of the patient’s condition.

b. Data including lab values and results of other diagnostic studies which may affect the condition being evaluated.

c. Reason for the consult.

d. Consultation results will be documented electronically as a consult progress note, and include the recommendations for treatment.

3. **(CWAD)** CRISIS NOTES, WARNING NOTES, ALERGIES/ADVERSE REACTIONS, ADVANCE DIRECTIVES

Select information vital to patient care and employee safety will be entered as progress notes or allergies/adverse reactions within the electronic medical record, and will be accessible to authorized users having access to CPRS.

a. General Definitions

(1) Crisis notes - are not used at current time but maybe considered in the future.

(2) Warning notes - contain summarized information about conditions that require specific treatment plans to be followed. Examples are: suicidal behaviors that include threats and attempts, assaultive behavior, violent behavior, elopement risk, fall risk, research study participants, opioid analgesic agreements, etc.

(3) Allergies/adverse reactions - identifies drug, nutritional and other allergen related events.

(4) Advance directives – Alerts staff to the existence of an advance directive. This grouping also includes the Code Status note and Out-of-Hospital Orders note.

b. Clinical staff is responsible for recording/posting CWAD notes and allergy/ adverse reactions, accurate updates and/or rescissions. Updates and rescissions are accomplished by the entry of most current allergy/adverse reaction information or addendums to original notes or the entry of the appropriate note title rescinding the original note in the clinical record .

4. Any education provided will be documented in the note titled, education record so the information is retrievable by title.

5. Dialysis: patient information data will be utilized for all patients. Nursing documentation during hemodialysis treatments will follow unit policy. Minimally, a note will be entered pre-, mid-, and post-treatment on medically stable patients. Monitoring of high-risk patients will occur more frequently. All patients will be observed on a continuous basis during their therapy. Nursing documentation for dialysis patients can be located in the database program.

C. Outpatient Documentation

1. A progress note will be documented for each patient encounter including telephone contacts and visits to community based care clinics. Each note will contain the following elements:

a. Date of visit/encounter

b. Clinic in which patient is being seen

c. Practitioner's name, title and signature

d. Chief complaint or reason for visit

e. Relevant history, examination findings, and prior diagnostic test results as appropriate

f. Identification of risk factors as appropriate

g. Assessment, clinical impression, or diagnosis

h. Plan for care

2. Primary care outpatient documentation

It is the expectation that all documentation be completed (signed or dictated) by close of business day. The provider has three work days to sign uploaded, dictated reports.

3. A CPRS progress note must be completed for patients presenting to the emergency department. The documentation must include:

a. Any care that was provided to the patient prior to arrival

b. Time and means of arrival

c. Presenting Problem(s) (i.e. reason for visit)

d. History and objective data relevant to the presenting problem.

e. Assessment of the problem

f. Treatment plan for the problem

g. Primary and secondary diagnosis dealt with at this encounter

h. Basis for ordering tests, consults, or changes in medication

i. Final disposition, condition on discharge, instructions for follow-up care – If a patient leaves against medical advice this must be documented as part of the note.

4. Any patient receiving continuing ambulatory care services must have a problem list completed by the third ambulatory care visit. The problem list is to be reviewed on a continuous basis and as problems are resolved, the date of resolution must be entered. The problem list is to include:

a. Known significant medical diagnosis and conditions

b. Known significant operative and invasive procedures

c. Known significant adverse and allergic drug reaction – these must also be entered into the allergy package of Veterans Health Information System and Technology Architecture (VISTA).

5. An annual evaluation is required for all patients active within a clinic for over one-year. The treating physician is to review the treatment plan, indicate whether or not the Veteran is to continue in the clinic, complete a physical or mental status exam, and indicate the diagnosis treated in that clinic. This evaluation will be documented as a progress note.

6. When outpatient care is no longer required a summary note will be completed.

7. Communication center contact calls will be documented via CPRS Progress note.

a. A transfer template will be completed by the communication center staff in the following circumstances:

(1) A Community Hospital Referral Note will be completed when an active patient within VA Pittsburgh Healthcare System (VAPHS) is requesting transfer from a community facility and is NOT accepted in transfer at the time of the call. The primary care provider (PCP) is to be an identified co-signer of the note.

(2) A Communication Center Note will be completed for community hospital/VA hospital referrals on the day the patient is accepted for transfer to VAPHS.

D. Inpatient Documentation: All documentation will be completed electronically via CPRS or other approved electronic packages that interface with CPRS and/or VISTA Imaging.

1. A complete history & physical (H&P) exam will be completed within 24 hours of admission for all acute care admissions. This note must be documented or co-signed by a clinician with attending privileges. The documented H&P will use the titled History and Physical Exam and can be done using pre-established templates.

2. Code status must be documented in a separate note titled code status.

3. The initial nursing assessment is initiated within eight (8) hours and completed within twenty four (24) hours of admission and is documented in the progress note titled nursing assessment.

4. Progress notes:

a. The Admission Note must be completed within twenty-four hours by the attending physician.

b. All patients on the seriously ill list must be documented by nursing on the progress note at least once every 8 hours.

c. A nursing progress note will be written once per shift for the following:

(1) Admission

(2) Invasive diagnostic testing

(3) Invasive procedures

(4) A patient incident

(5) Surgery

(6) Transfer from the critical care units

d. Documentation will be continued every eight hours or more frequently as appropriate if the patient incurs complications or fails to stabilize.

e. Progress notes will provide a chronological record of each patient's care. They will contain pertinent clinical observations and interventions and document the Veteran's progress towards achieving goals listed in the plan of care note.

f. The attending will document a progress note when there is a change in the Veteran's condition as evidence of ongoing involvement.

g. Transfer notes identifying patient status are to be written by the registered nurse each time a patient is transferred to or from a nursing unit. Transfer notes are not in lieu of a verbal report.

(1) The transferring unit nurse manager/charge nurse should be notified immediately if the transfer note is absent or of poor quality. Arrangements will be made to correct the deficiency.

(2) When the patients are transferred from one VA to another, the CPRS note titled Discharge/Transfer Nursing will be completed to facilitate continuity of care and assure safe transfer.

h. A Death Note will be completed by the clinician pronouncing the veteran deceased and will include time of death.

i. For those patients who remain an inpatient for greater than one year, an annual assessment as well as an annual physical must be completed. This will be documented in the progress notes and titled Annual Exam.

j. Discharge/Transfer Nursing progress note will be completed at time of discharge from hospital by the registered nurse.

5. A Discharge Summary will be completed for all releases from inpatient care. The summary must be signed by the attending physician. Each Discharge Summary must contain the following information:

a. Diagnosis (significant findings)

b. Procedures performed

c. Reason for admission

d. Treatment performed, including education

e. Patient's condition at discharge

f. Instructions to patient and family

6. Orders: See also MCM MS-003 Professional Orders

a. The Admission Order must be completed for EVERY admission to the facility. This includes an order for admission to the Domiciliary (DOM), the Community Living Center (CLC), acute units at UD, and observation units. The Admission Order must be entered by a licensed clinician as defined in the medical staff by-laws. The Admission Order must contain the following information:

(1) Admit to : (unit)

(2) Treating specialty/ team:

(3) Attending:

(4) Admission date:

(5) Reason for admission/ diagnosis:

(6) Condition

b. A Discharge Order will be entered by the clinician determining that the veteran can safely be discharged from inpatient care.

7. Treatment Plan – Plan of Care (see MCM TX-131 Interdisciplinary Plan of Care University Drive)

a. The plan of care will be documented within 24 hours of admission by an RN in the Plan of Care Initial Team Note and will include the major patient problems/nursing diagnosis, and measurable expected patient outcomes/goals. The plan of care is reviewed every twenty four (24) hours and updated.

b. Reassessment: the registered nurse will initiate when a significant change occurs in the patient's condition or when a significant change occurs in the patient's diagnosis. The reassessment process will include the patient's response to treatment and include a time frame related to the patient's course of treatment.

8. Critical care monitoring/flowsheet documentation shall be through the PICIS software which is downloaded daily to VistA imaging. All other documentation requirements are completed as other units of the hospital. See also MCM TX-072 Critical Care Center Policy

E. Psychiatry

1. Admission orders and admitting physician progress note include statement of voluntary or involuntary treatment status.

2. The history and physical exam includes a mental status exam.

3. A psychosocial assessment is completed by the social worker within three days of admission. For readmission within 30 days, a new note titled Psychosocial Assessment shall be documented referencing the date of the prior assessment. There must be evidence of review of the prior psychosocial assessment in the documentation. If there has been no change in patient's status, a statement to that effect must also be reflected in the documentation.

4. Physician progress notes are written each administrative workday by attending physicians while the patient is acute and at least weekly by the attending physician or more often if there are changes in patient's condition, for the first thirty days of an acute admission. For patients remaining over thirty days, the physician must document a progress note at least every thirty days. For acute psychiatric unit admissions, a treatment plan is initiated within 24 hours of admission by nursing utilizing the Mental Health Treatment Planner and co-signed electronically by the attending MD/provider. On acute inpatient psychiatry units, a nursing progress note is documented every shift for the first two days of admission for a total of six notes, and then each day on the day and evening shift or if the patient's condition changes. The nursing progress note will include documentation on nursing assessment, patient progress towards identified

goals from the treatment plan, assessment of suicidal/homicidal ideation and any issues experienced by patient during hospitalization. Psychiatric and medical terminology will be utilized. For admissions to extended psychiatric units, any previous patient treatment plan will be reviewed by nursing. A new treatment plan will be initiated upon transfer to the unit and cosigned electronically by the attending physician/provider. A nursing progress note will be done daily for seven days, and then weekly for the remainder of the admission, or as goals are met or patient condition changes.

5. Psychiatric unit treatment team meetings will be documented in CPRS by nursing at least weekly for acute psychiatric units and at least monthly for extended psychiatric units.

F. Surgical Patient

1. Surgical Consents

a. iMed Consent must be used except for administrative consents or approved exceptions (see MCM RI-010).

b. When paper consent form (10-0431a) is used, all three pages must be completed or marked as non-applicable. The consent form serves as documentation of explanation to the patient of possible adverse effects provided all entries have been completed.

2. Peri-operative reports

a. All surgical patient records should have a history and physical examination entered by the provider to include diagnosis, procedural plan, any specific considerations as indicated (e.g. anesthesia restrictions, blood product limitations). The history and physical examination must be within 30 days and include an update within 24 hours of the operation. Attending concurrence must be documented including need for postoperative admission if indicated.

b. A brief post-operative note must be documented immediately after the procedure. *NOTE: The Joint Commission defines immediately as "upon completion of the operation or procedure, before the patient is transferred to the next level of care." NOTE: Operative reports that are generated immediately utilizing a templated note available in the medical record at the end of the procedure before transfer to the next level of care obviate the requirement for an immediate postoperative note.*

c. The Operation Report dictation should be completed immediately after the procedure. The operative report will be documented in the following format:

(1) Pre-operative diagnosis including contributing or complicating diagnoses.

(2) Post-operative diagnosis

(3) Procedure

(4) Primary surgeon & assistants

(5) Anesthesia administered

(6) Findings (including pertinent normal findings)

(7) Complications

(8) Condition of the patient upon leaving the operating room.

(9) Any tubes or lines that were placed into the patient, (e.g. drain, central lines, Swan-Ganz catheters, etc.)

(10) The attending surgeon must indicate his presence by signature.

(11) Specimens removed

G. Community Living Center (CLC)

1. Care plan/interim plan of care

a. An interim care plan is formulated within the first twenty-four hours by the registered nurse.

b. An Interdisciplinary Treatment Plan note must be completed within the first 14-21 days. This is done at the first treatment team meeting by reviewing the interim care plan and other problems identified from the service specific admission assessments and the triggered Minimum Data Set (MDS) Resident Assessment Protocols (RAPS), and prioritizing which problems should be included in the care plan.

c. After the initial 21 day interdisciplinary meeting, the team will meet every 90 days to review and revise the patient's care plan except in skilled care which meets every 30 days on each patient remaining on the unit. (Documentation is on the H.J. Heinz Interdisciplinary Team Note shared template; see Interdisciplinary Resident Care Management TX-100.)

2. Progress note – Nursing service summary nursing home care unit's progress notes will be entered every shift for the first twenty-four hours of admission. Progress notes will be completed monthly, or more frequently as indicated by the resident's condition.

3. Provider **Documentation requirements**

a. Every resident admitted or transferred to the HJ Heinz Community Living Center will be seen by a provider upon the same day of arrival. At that time, either a brief admission note documenting the reason for admission, the current condition of the individual, and a brief outline of the therapeutic plan or an **Admission-Community Living Center-Provider Note** will be done. If a brief note is done, then an admission history and physical (titled **Admission-Community Living Center-Provider Note)** will be completed within 48 hours. If the resident is a new admission, the **new admission** template will be used. If the resident is Away Sick In the Hospital (ASIH) and is being returned to the CLC, the **return from ASIH** template will be used. If the **Admission-Community Living Center-Provider Note** is done by someone other than either the attending physician or CRNP assigned to that unit, then the attending physician must place a note in CPRS the first business day after the resident's admission detailing the resident's course since admission, his current physical condition, and the therapeutic plan. As part of the admission process, a medication reconciliation will be done.

b. Within 72 hours of admission, the code status will be reviewed with the resident and/or the surrogate decision-maker. This will be documented by either making an addendum to the existing Code Status note or by completing a new Code Status note.

c. After admission, the resident will be seen at approximately 14, 30, 60, and 90 day intervals after admission and then every 60 days. The purpose of this visit will be to see the resident, perform a focused physical examination, record the progress and problems in maintaining or improving their mental and physical functional status, and review the total program of care, including medications

or treatments. Documentation of these visits will be by using the CPRS note titled **Community Living Center provider review of care.**

d. In addition to the above, additional documentation will be required in the following situations:

(1) Whenever there is a significant change in the resident's physical and/or functional condition, care, treatment, and services. This documentation can be accomplished by using either the Community Living Center Provider Review of Care Note, the HJ Heinz Inpatient Attending Note, Medical Officer on Duty (MOD) Note, or the nurse practitioner/physician assistant note. If the MOD note or the nurse practitioner/physician's assistant note is used, the attending physician should be listed as a cosigner.

(2) Whenever a resident is seen by a provider for a specific concern.

(3) To review and comment upon a consultant physician's recommendations for consistency with the interdisciplinary plan of care.

(4) To comment upon the course of events leading to an expected death.

(5) To comment upon lab or imaging results and to document any changes in the therapeutic plan based upon these results.

(6) An annual physical examination must be completed for inpatients in nursing home care should the patient's length of stay exceed 365 days.

(7) As required by existing policies. Examples would include the Inter-Facility Transfer note and the Post Fall Provider Note.

H. Specialty Programs

1. Respite Care (see MCM TX-4)

2. Documentation Guidelines for the Domiciliary Residential Rehabilitation & Treatment Program for Homeless Veterans (DCHV) (See MCM IM-16)

3. Center for the Treatment of Addictive Disorders Treatment Procedures & Documentation Guidelines (see MCM TX-109)

4. PRRTP for Seriously Mentally Ill (PRRTP-SMI) (see MCM TX-117)

5. Compensated Work Therapy/Transitional Residence Program (CWT/TR) Admission Policies and Procedures (see MCM TX-28)

6. Hospice and Palliative Care Program (see MCM TX 202)

7. Community Support Program (CSP) Mental Health Intensive Case Management (MHICM) (see MCM TX-50)

8. Community Residential Care (see MCM TX-33)

9. Oncology Treatment Unit (see MCM TX-21)

10. Healthcare for Homeless Vets (see MCM TX-89)

11 9West Short Stay Unit (see MCM TX-217)

I. Ancillary Services

1. Dental

a. Long term inpatients will have a dental examination performed within fourteen days of admission to CLC documented in CPRS and findings charted in Dental Record Manager (DRM). Subsequent oral examinations will be performed at six-month intervals following the time of last examination or completion of the last episode of treatment. If patient is edentulous subsequent oral examinations will be performed annually. Any subsequent treatment will be documented in CPRS and Dental Record Manager (DRM)

b. Inpatients not categorized as long term care, who receive dental care will also have a dental examination documented in CPRS and findings charted in Dental Record Manager (DRM).

c. Eligible Veteran outpatients will receive a dental examination documented in CPRS and findings charted in Dental Record Manager (DRM). Subsequent treatments will be documented in CPRS and Dental Record Manager (DRM).

2. Recreation Therapy Program Documentation Guidelines (see MCM IM-14)

3. Pharmacy (see MCM TX-43 Administration of Medication)

4. Physical Medicine & Rehabilitation Services (see MCM TX-70)

5. Post Anesthesia Care Unit (PACU and Ambulatory Surgery Unit (ASU) Recovery Area Policy (see MCM TX-96)

6. Radiology – Results of all radiologic exams will be documented as a radiology report on-line in the radiology package. These will be electronically signed by the radiologist reading the film.

7. Audiology & Speech (see MCM TX-24)

8. Nutrition Screening, Assessment, Documentation and follow-up of Nutritional Care (see MCM TX-12)

IV. RESPONSIBILITY

The chief of staff or designee has oversight responsibility for health record timeliness, accuracy and completion. The supervising practitioner or attending physician is responsible for the accuracy of the health record for each patient under the physician's care. Health care providers that are responsible for documenting in the patient health record are responsible for adhering to the charting guidelines.

V. REFERENCES

VHA Handbook 1907.1 Health Information Management and Health Records
Computerized Patient Record System (CPRS) User Guide-GUI Version March, 2007

VI. RESCISSIONS

Memorandum IM-013, dated January 23, 2014.
Memorandum TX-175, dated April 26, 2011.

VII. CONCURRENCES

001, 002, 11, 11D, 00S, 00B, All service line VP's and AFGE 2028

VIII. EXPIRATION
This memorandum automatically expires on March 5, 2018.

//Signed//
DAVID S. MACPHERSON, MD, MPH
Acting Director

Attachment A: Forms Policy
Attachment B: Documentation Timeliness Requirements

FORMS POLICY revised 2013

ALL FORMS or TEMPLATES:

1. All forms and template requests will be sent electronically to VHAPTH Forms Team via Outlook.

   Template requests must be in a MS Word document, so that sections can be copied into the created template.
2. The request form must be completed for all form and initial template requests.

   The requestor will be notified if it is determined the form can be made into an electronic CPRS template.
3. Spelling and grammar should be checked.
4. Templates and paper forms will not contain any diagnostic or procedure codes as these are subject to change yearly.
5. Only approved abbreviations and symbols are used in the form/template or a legend is provided for any abbreviations not approved. For templates, abbreviations will be spelled out as much as possible.

   Approved abbreviations can be found in Medical Center Memorandum IM 003 and Stedman's.
6. All forms and templates must be reviewed and approved by the Forms Committee prior to being used.
7. All form and template requestors are responsible for coordinating and/or training those staff who will be using these items once approved.

PAPER FORMS:

1. Forms must be submitted electronically
2. Margins on all four sides need to be at least 1/4 inch wide.
3. There must be adequate areas delineated and labeled for all required signatures, including date and time.
4. Forms should be in a vertical layout. All exceptions will be by Forms Committee approval only.
5. If the form is more than 1 page, each page will be identified 1 of 4, 2 of 4, 3 of 4, 4 of 4, or such in the footer of the page. The title of the form will also show on each page in the header.
6. If revisions are required by the Forms Committee, the requestor is expected to make the changes and return the revised form for final approval. The Forms Committee will provide an official form number when approved for use. The requestor or Forms Committee will add the form number and official CIT approval date to the right side footer.
7. All approved paper forms will be saved onto the VAPHS Forms SharePoint site for future printing.
8. If approved, the form's requestor is responsible for staff training, reproduction, and dissemination/distribution. If the form is a revision, the requestor is also responsible for removing earlier versions from supply areas.

STANDARD BLOCK FORMATTING:

Upper Left or Across Top: VA PITTSBURGH HEALTHCARE SYSTEM

Upper Right: Form Title

Lower Left: Patient Identification information

Lower Right:

a. Line 1: Form number
b. Line 2: VAPHS and CIT approval date

Documentation Timeliness Requirements

Documentation Requirement	Acute Care (includes all inpatient units at UD site)		Surgery		Observation	
	Due by	Becomes Delinquent	Due by	Becomes Delinquent	Due by	Becomes Delinquent
H&P	24 hours of admission	30 calendar days from date of discharge	24 hours of admission/within 30 days prior to surgery **(must be done prior to surgery requiring anesthesia)**	30 calendar days from date of discharge	on admission	30 calendar days of date of discharge
Discharge Summary	24 hours of discharge or death	30 calendar days from date of discharge	24 hours of discharge or death	30 calendar days from date of discharge	24 hours of discharge, death or transition to acute care	30 calendar days of discharge — a discharge note in lieu of a summary
Operation Report			immed post op	30 days after discharge		

Documentation Requirement	Dom		PRRT		CLC	
	Due by	Becomes Delinquent	Due by	Becomes Delinquent	Due by	Becomes Delinquent
H&P	7 days of admission	30 calendar days from date of discharge	7 days after admission	30 calendar days from date of discharge	72 hours of admission	30 calendar days from date of discharge
Discharge Summary	24 hours of discharge or death	30 calendar days from date of discharge	Day of discharge	30 calendar days from date of discharge	72 hours of discharge or death	30 calendar days from date of discharge

References: HIMS Handbook 1907.01 Sept 2012
Medical Staff By-Laws
JC - Record of Care standards
MCM IM-016 Documentation Guidelines for the DOM May 2013
MH RRTP Handbook 1162.02 Dec. 2010
VHA Directive 2009-064 re: Observation Nov. 2009