DEPARTMENT OF VETERANS AFFAIRS
NORTH TEXAS HEALTH CARE SYSTEM

August 28, 2008
549/04D

VANTHCS MEMORANDUM NO. 04D-09

AUTHORIZATION FOR MEDICAL RECORD ENTRIES AND DOCUMENT COMPLETION REQUIREMENTS

1. **PURPOSE:** The purpose of this policy is to ensure that a complete, concise, legible and accurate medical record will be maintained and readily accessible for every patient treated at VA North Texas Health Care System (VANTHCS) and to ensure only authorized individuals make entries in the medical record. Authorized individuals shall utilize the procedures for signature, credential and title designations described in this policy.

2. **POLICY:**

a. The quality and standards for recording data during a period of ambulatory/outpatient care will be similar to inpatient care. The documentation requirements for inpatient medical records will apply as appropriate.

b. All records will be completed within 30 days following the release of the patient from inpatient care. To meet this requirement, the following timeframes will be enforced:

(1) History and physicals completed within 24 hours of admission.

(2) Discharge Summaries dictated on or before the day of discharge (death/irregular-24 hours after release from care).

(3) Discharge Summaries transcribed within three working days of dictation.

(4) Discharge Summaries signed within three working days of transcription.

(5) Discharges coded and entered into Patient Treatment File prior to the specified close out dates each month.

(6) Operative Reports dictated immediately after surgery.

(7) Operative Reports transcribed within three working days of

dictation.

(8) Operative Reports signed within 24 hours of transcription.

(9) Attending physicians/service chiefs are responsible for completion of undictated/unsigned history and physicals, discharge summaries, and operative reports.

For records that are not completed within 30 days, the appropriate service chief will be notified and corrective action requested.

c. Medical records are considered complete when the following documents are present, signed, and co-signed when appropriate:

(1) Discharge Summary

(2) History and Physical

(3) Operative Reports

(4) Doctor's Orders

(5) Consults

(6) Diagnostic and Therapeutic Procedures

d. Following discharge from inpatient care, the paper portion of the Consolidated Health Record (CHR) will be compiled/audited, analyzed, and, if complete, then forwarded to the File Room for filing.

(1) If any of the above documents are still incomplete, Ward Administration staff will contact the provider and facilitate completion of the record. When the record has been completed, it will be noted.

(2) Medical Administration Service (MAS) will provide a monthly aggregate summary of overall and service-specific record completion timeliness. Applicable reports are distributed to all services and presented to Executive Committee of the Medical Staff (ECMS).

(3) The Individual Reappointment Profile (IRP) Coordinator will provide physician-specific completion timeliness of dictation of discharge summaries and report it to Clinical Quality Management (CQM) on a quarterly basis for inclusion in the physician's Individual Reappointment Profile (IRP) folder.

3. **PROCEDURES:**

a. Authorization for Medical Record Entries and Documentation of Supervision.

(1) Only providers (clinical employees, including contract and fee-basis staff, medical students, residents, and fellows) are authorized to document care in the patient's medical record. Administrative personnel may make appropriate non-clinical notations in the patient care record. Opinions requiring medical judgment must be documented or authenticated only by medical staff members and other individuals who have been granted such clinical privilege.

(2) Care will be documented in CPRS. Each provider is responsible to ensure that entries are accurate, timely, and complete. Each entry must be signed electronically.

(a) History and Physical Examinations and Discharge Summaries performed by residents, physician assistants, or Advanced Practice Nurses will be counter-signed by the responsible attending medical staff member.

(b) Staff physicians will document concurrence with the plan of patient care by progress note or by documenting an addendum to the primary provider's note by midnight the day following the date of admission.

(c) Medical staff members will only be required to authenticate their own entries or those made by staff they supervise in the care of a patient.

(3) Entries that cannot be entered into CPRS will be entered on paper and dated and signed in blue or black ink. All entries will also be:

(a) in English and legible.

(b) handwritten, dictated, or transcribed.

(c) in chronological sequence, if possible.

(d) timely following examination, treatment, and observation.

b. Mandatory Inpatient Documentation

(1) Problem List: The patient's problem list should serve as an index for the patient's medical record. Clinicians (attending staff, residents, Advanced Practice Nurses and/or Physician Assistants) are responsible for updating the problem list.

(2) History and Physical Examination: This document must reflect the initial medical evaluation including documentation of present state of health and a comprehensive review of all pertinent factors in the patient's previous health history. Initial history and physical shall be dictated/completed and incorporated into the patient's medical record by the admitting provider within 24 hours of admission. History and physical for scheduled admissions may be completed up to 30 days prior to the scheduled admission for surgery.

(3) Treatment Plan: A treatment plan will be established for each patient who begins care at VANTHCS. The plan will be documented in the progress notes and specify diagnostic and therapeutic modalities. Revisions are made as necessary, and the problem list is updated to remain concurrent with the plan.

(4) Progress Notes: Progress notes are recorded by all levels of clinical staff as appropriate. Each progress note contains relevant patient comments, observations, and education provided to patients and significant others. Clinicians are responsible for entering changes in plan or diagnostic developments.

(5) Doctors Orders for Inpatient Care: Orders are entered and signed in CPRS by responsible primary or attending physicians with ordering privileges, with the following exceptions:

(a) Orders for chemotherapy, total parenteral nutrition, and outpatient narcotics.

(b) Orders entered into CPRS by clinical staff authorized to accept telephone orders. These orders have the CPRS nature of order "telephone". The requesting clinician will electronically sign these orders within 24 hours (or on return to work if orders are given while off-site). Signatures by surrogate clinicians, such as attending physicians, team members and service appointed physicians are acceptable.

(c) Orders that are automatically generated in CPRS as a result of entries made in VISTA clinical packages (Laboratory, Pharmacy, Nutrition and Food Service, and

Radiology) in response to handwritten clinician orders. These orders have the CPRS nature of order "written on chart" and are not printed on computer generated work copies or order summaries for inclusion in the patient chart.

(d) Orders entered into CPRS by clinical staff carrying out activities covered by VANTHCS policy. These orders have the CPRS nature of order "policy". An example would be a consult entered by a nurse to Nutrition and Food Service for a newly admitted patient with difficulty in eating.

Nursing and MAS staff notate orders electronically. Inpatient orders print to a designated printer on the unit. Unit Clerks are responsible for filing these orders in the patient record. During computer downtime, orders are written on VA Form 10-1158 by relevant staff. Once the system is restored, the 10-1158 should be routed to the file room to be scanned in to Vista Imaging.

(6) Informed Consent: Standard Form 522 “Informed Consent” will be used where appropriate. (Refer to VANTHCS Memorandum ET-03 “Informed Consent”). VA Form 10-1086, “Agreement to Participate in the Research by or Under the Direction of Department of Veterans Affairs” will be used where appropriate. Consent will be obtained prior to entry in research protocols. Informed Consents will be scanned into Vista Imaging or by direct scan upon signing in the IMED System.

(7) Operation Report: The surgeon is responsible for dictation of the operative report/note immediately following the procedure. Other invasive procedures are documented in progress notes in CPRS or a paper report provided for inclusion in the CHR.

(8) Non-Operative Procedures: These will be documented in CPRS via progress note or on paper.

(9) Discharge Summary:

(a) Discharge summary will be prepared for all releases from hospital care, including deaths. The summary will include statements relating to those conditions evaluated or treated during the period of hospitalization.

(b) The provider with responsibility for the care of the patient at the time of discharge shall be responsible for the dictation of the discharge summary. The attending physician has ultimate responsibility for assuring dictation of the discharge summary.

(c) All discharge summaries will be dictated on or before the day of discharge. All summaries for transfer to another VA facility or contract nursing home will be dictated as soon as possible following the decision/acceptance of transfer. Every attempt should be made to dictate no later than 4:30 p.m. on the day prior to discharge. Discharge summaries dictated more than three days in advance of the patient's discharge require an addendum at the time of discharge to document changes in condition and/or explain the delay in discharge.

(d) Incomplete discharge summary lists are distributed weekly from Transcription to the Director, Chief of Staff, and clinical service chiefs.

(e) One week after a resident completes a rotation at this facility, all undictated discharge summaries, become the responsibility of the supervising resident. If the supervising resident has completed his/her residency at this facility or there was no supervising resident, the attending physician is responsible for dictating the discharge summary.

(f) If the attending physician of record is no longer employed at this facility, either another attending physician or the chief of the applicable clinical service may complete the progress note or other document administratively by preparing a summary of the course of treatment based on existing patient documentation. The following statement should be included in the documentation:

"This note is being signed/created for the administrative purpose of completing the following discharge: *admission date* to *discharge date*. This signature does not imply any knowledge of the patient or validity of the contents of this progress note/summary."

c. Mandatory Ambulatory Care Documentation

When a patient initiates VA care on an ambulatory/outpatient basis, s/he will be given an initial evaluation that is fully equivalent to that of an inpatient.

(1) A progress note will be documented electronically at the time of each ambulatory care visit. Each progress note will contain:

(a) name of the clinic

(b) date of the visit

(c) reason for visit; presenting problem

(d) assessment of the problem

(e) treatment plan

(f) reason for ordering tests

(g) consults of changes in medications

(h) diagnoses treated

(i) recommendations for follow-up care

(j) patient instructions

(k) and the signature and professional designation of provider.

(2) Progress notes will be completed and signed the same day the patient is seen. A monthly list of incomplete progress notes will be distributed to the clinical service chiefs for completion by each responsible author.

(3) If there is a clinical reason to record a no show visit a progress note can be written.

(4) Progress notes started prior to an outpatient visit should not be signed until the time of the visit. If the patient does not keep the appointment, delete the note unless there is a clinical reason for the note.

(5) The medical records for patients receiving continuing ambulatory care services will contain a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications. The list is initiated by the third visit and maintained thereafter.

(6) If a patient is on ambulatory/outpatient status for a year, at the time of the next visit, the patient will be given an annual physical or as applicable, an assessment of the condition for which care is authorized. The mental status of psychiatric patients will also be re-evaluated at the time of the annual physical. The examining provider will determine the comprehensiveness of the examination based on the age, sex, and previous and current health status of the patient.

(7) When a patient is released from an episode of ambulatory or outpatient care, a summarization of the period of care must be recorded on an electronic progress note. This summary will include:

(a) all relevant diagnoses for which treatment was provided

(b) all operative procedures performed

(c) significant findings

(d) condition of the patient

(e) any specific instructions given to the family regarding physical activity limitations

(f) diet

(g) medications

(h) follow-up

(i) date ambulatory care was terminated

(j) the signature of the medical staff member authenticating the summarization, and the date.

d. Emergency Department Visits

Documentation of emergent care will include:

(1) time and means of arrival

(2) care received prior to arrival

(3) presenting problem

(4) history and objective data relevant to presenting problem

(5) care rendered

(6) condition at discharge

(7) final disposition

(8) and patient discharge instructions.

In cases involving a death, a death progress note is required.

4. **RESPONSIBILITIES:**

(a) Clinical service chiefs are responsible for the timely and accurate completion of medical records. They are also responsible for following their service level policy for content and frequency of documentation in addition to healthcare system requirements.

(b) Staff physicians are responsible for ensuring that their medical records, and the medical records of the residents under their supervision, are completed on a timely basis and contain accurate and complete documentation.

(c) All clinical staff are responsible for selecting electronic notes/templates by correct note title, for completing and signing notes the same day that the patient is seen (an unsigned note is unavailable to other staff for reference), and for including their title in their electronic signature. Clinical staff are also responsible for updating any note partially formulated by copying and pasting to describe the patient's current status; for using only approved abbreviations; and for including the rationale for treatments ordered.

(d) The Transcription Supervisor in MAS is responsible for the administrative processing of medical records, including: quantitative and qualitative analysis and advising the Chief of Staff and clinical service chiefs relative to the status of medical record completion, as well as issues with medical record documentation and for the confidentiality, security, integrity, and storage of the paper record.

(e) The Medical Records Committee is responsible for reviewing medical records for timeliness of completion and for the overall quality. Through review of a representative sample of medical records, the Committee assures that medical records reflect: the diagnosis, results of diagnostic tests, surgical/invasive procedures completed, therapy rendered, conditions, in-hospital patient progress, patient condition at discharge, and a discharge summary. The Committee also controls all medical record forms including electronic templates, overprinting and record assembly.

(f) The Information Management Committee is responsible for the confidentiality, security, integrity, and storage of the Electronic Medical Records.

(g) The Clinical Applications Coordinator is responsible for providing education and training on all clinical packages of the electronic record to the clinical staff.

5. **REFERENCES:** Veterans Health Administration Handbook 1907.1 dated August 25, 2006, 2008 Joint Commission Standards; and VANTHCS Medical Staff Bylaws March 18, 2008.

6. **RESCISSION:** VANTHCS Memorandum MR-7, dated January 31, 2007.

Joseph M. Dalpiaz
Director

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