MEDICAL RECORD MANAGEMENT

1. **PURPOSE**:

a. To establish policy and procedures for Phoenix VA Health Care System (PVAHCS) and the Community Based Outpatient Clinics (CBOCs) to ensure timely, accurate, complete, clinically pertinent, and readily accessible patient health information which will contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, support education and research, and document measurable outcomes.

b. Title 38 United States Code (U.S.C.) 7304(a) is the statutory authority for the Under Secretary for Health to promulgate regulations concerning the custody, use, and preservation of records and papers of the Veterans Health Administration (VHA).

2. **POLICY**:

a. The Consolidated Health Record (CHR) will be created and maintained for every individual assessed or treated, as well as for those receiving community or ancillary care at VA expense; Veterans examined for possible exposure to toxins, asbestos, radiation or other environmental contaminants; those undergoing Compensation and Pension examinations; and collateral or family members of veterans attending counseling.

b. The medical record is the property of the medical center and is maintained for the benefit of the patient, the medical staff, and the medical center. The medical record can be paper, computer based (electronic), or a combination of paper and electronic data. 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 CHR.

c. The most current standards of the Joint Commission will be followed, unless otherwise specifically stated by VA regulations or requirements as set forth by the most current Medical Staff Bylaws, Rules and Regulations.

d. Protection of confidentiality and privacy of patient information shall be ensured, including, but not limited to, compliance with Privacy Act of 1974, Freedom of Information Act (FOIA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Information contained therein will not be accessible to, or discussed with, unauthorized persons. Authorized individuals must have an identifiable need for the record to perform their assigned

duties. Please refer to Policy Memorandum Numbers 00/PO-01 Privacy Policy; IS/IRM-12, Electronic Mail (E-Mail); and Veterans Health Administration Handbook, 1605.1 "Privacy and Release of Information."

e. All medical record forms (paper and electronic), the overprinting, assembly and use thereof will contain, as minimum identification, the patient's name, social security number, and facility location (VAMC, Phoenix, AZ). Refer to Appendix E.

f. Only symbols and abbreviations listed within the *Stedman's Abbreviations, Acronyms and Symbols* publication will be used in the patient medical record. The following are unapproved use of abbreviations: This applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

Abbreviation/Dose Expression	**Intended Meaning**	**Misinterpretation**	**Correction**
IU	International Unit	Mistaken as IV (intravenous or 10 (ten)	Use "international unit"
MS, MSO*4, MgSO4*	Morphine Sulfate Magnesium Sulfate	Confused for one another	Use "morphine sulfate" or "magnesium sulfate"
Q.D., Q.O.D., QOD,q.o.d.,qod, (every other day) QD, q.d., qd(daily)	Once daily and every other day	Mistaken for each other. The period after the Q can be mistaken for an "l" and the "O" can be mistaken for "l".	Use "daily" and "every other day"
U	Unit	Mistaken as zero, for or cc	Use unit
Trailing zero (X.O mg)* Lack of leading zero (.xmg)	Xmg	Decimal point is missed	Use X mg or use 0.X mg

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

g. Following release of an inpatient stay, the medical record will be assembled and transported within 24 hours to the control of Health Information Management Service (HIMS) for appropriate scanning into CPRS.

h. The medical record received from an acute care admission into the Community Living Center will remain on the CLC floor for only one week prior to delivery to the Health Information Management Service.

i. The medical record shall be complete within 30 calendar days from the date of discharge before a record will be considered complete. Problem cases will be referred to the Clinical Executive Board for final disposition.

j. Records shall be kept and preserved for a period of time not less than that determined by the Records Control Schedule or when approval is received from the Federal Record Center Director.

k. In the event of a disaster, patient records will be recreated based on available computer patient record information and/or hard copy records. If hard copy records are salvageable, they will be recovered and sent out to microfilm, in accordance with requirements in RCS 10-1. All records will be afforded protection against defacement, damage, loss, destruction by fire/flood, or other hazards.

l. Medical records may be removed from the medical center's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Medical records, however, will be transferred to another VA Medical Center or Community Based Outpatient Clinics (CBOC) upon request for purposes of maintaining a unit record.

m. The availability of computerized patient information within the Computerized Patient Record System (CPRS) precludes having to print hard copy material until such time that the record is transferred outside VISN 18. The Health Information Management Standard Chart health summary and Medication Administration Log will be the primary sources utilized in printing out patient electronic information upon transfer. Other VA Medical Centers can access patient information using Remote Data View through CPRS.

3. **DEFINITIONS**:

a. Active Record: The Consolidated Health Record (CHR) of a patient who is currently receiving care, regardless of patient status or location of care being rendered.

b. Addendum: Inclusion of additional information to source document.

c. Ambulatory or Outpatient Care: Health care services provided to patients who are not classified as inpatients. For purposes of CHR maintenance, ambulatory or outpatient care refers to all categories of care such as Outpatient-Service Connected (OPT-SC), Outpatient-Non-service Connected (OPT-NSC), Ambulatory Care; Home Based Primary Care (HBPC), etc.

d. Authentication: Approval of documentation in the patient record by means of a signature (manual or electronic), computer key or other means recognized legally. Authentication demonstrates the entry has not been altered, and affirms the validity of the author's actions(s), opinion(s) or statements. Authentication will consist of date, signature, initials or

defined computer entry, time if required, and professional designation of the member of the patient care team making the entry.

e. Computerized Patient Record System (CPRS): An electronic patient record stored in Veterans Health Information System and Technology Architecture (VISTA), or other automated system using electronic storage system, e.g., optical disk, that provides easy retrievability of complete, accurate, and timely medical information.

f. Consolidated Health Record (CHR): The CHR (commonly referred to as the 'Medical Record') is the combination of the electronic and paper record. The CHR can be called the medical record, the patient record, the health record, the electronic health record and/or the computer-based patient record. The CHR contains two parts, housed in two folders:

(1) Type I, Administrative Records Folders, contains documents pertaining to a patient's demographics, eligibility, and other business-related documents.

(2) Type II, Medical Records Folder, contains health care documents related to all aspects involved in healthcare delivery. It is individually identifiable data, in any medium, collected and/or directly used in documenting health care.

g. Retired Record: A record stored off site, at a Federal Records Center (FRC), or archived to electronic storage medium. Records are retired after three years of inactivity or two years from date of death.

h. Scan/Scanning: Capture of data via imagining/pictorial technology.

4. PROCEDURES:

a. General:

(1) The primary source of documentation for all patient care activities shall be Computerized Patient Record System (CPRS). VAMC Phoenix has established the goal of a transition to a paperless electronic medical record. Computer-generated medical record documentation does not currently eliminate the need for hard copies of specific patient medical records. The CPRS initiative is to achieve a complete electronic medical record.

(2) A concise clinical resume, progress note, or transfer summary will be included in the medical record at the time of inpatient discharge or transfer to provide important information to other caregivers and facilitates continuity of care.

(3) Medical and administrative processing of records, including qualitative and quantitative analysis, final coding, and completion of deficiencies by responsible parties

will be accomplished within established timeframes outlined in Appendix B, Clinician Documentation Quick Reference.

(4) Each time a patient visits the ambulatory care setting, a progress note will be recorded preferably through CPRS. Documentation should include the following: date and clinic title, chief complaint, relevant history of illness or injury, clinical observations, results of treatment, reports of tests, procedures performed, doctor's orders for medication, tests, therapy, work/activity limitations if any, diet when appropriate to clinical condition and follow-up, instructions to patient including level of understanding, signature and title of author. Evaluation and Management levels are calculated using Centers for Medicare and Medicaid Services 1997 E & M Guidelines for Mental Health, Neurology, and Ophthalmology encounters and uses Centers for Medicare and Medicaid Services 1995 Evaluation and Management Guidelines for all other encounters. Supporting documentation by the provider will encompass these guidelines.

(5) The problem list will be initiated and maintained by the third visit to the health care provider and shall include known significant diagnosis, conditions, procedures, drug allergies and adverse reactions. Entries other than diagnosis, if significant for the information of the health care team, may be recorded on the problem list. The health care problems listed will not be numbered and the list will be updated as necessary upon subsequent outpatient visits. Problems identified will be listed as chronic, acute or historic.

(6) The Clinical Reminder package will be used to document the assessment and counseling of chronic disease indexes and preventative health issues. Information documented on this form will also be reflected in the visit progress note. The encounter form will be used to address clinical reminders pertaining to the relevant chronic disease index and preventative health issues.

(7) Each medical record will have at least the following component parts: Discharge summary (see Appendix A for specifics), history and physical examination, progress notes, vital signs, Dr.'s Orders, a comprehensive multidisciplinary treatment plan, and nursing care documentation. When applicable, the record will include informed consent or documentation of administrative consent, operation reports, pathology reports, and autopsy findings.

(8) Medical records will contain original and/or electronically authenticated documents. Signature, initials (where applicable), defined computer entry, professional designation, staff title and date will authenticate all entries in the record. The signature in the electronic record will be electronically timed stamped upon completion.

(9) No edit or alteration of any documentation shall occur after manual or electronic signature has been completed. The only exception is through education of our house staff and student's, i.e. discharge summaries and Podiatry medical student progress notes. Once the record is edited by the supervising physician, the document can no longer be

edited or altered. Records will not be erased, whited-out or marked-over. Errors or omissions found within patient records should be brought to the Chief, HIMS's attention for resolution.

In CPRS documentation can be edited on line prior to authentication with an electronic signature. After a document is signed all corrections need to be done through Privacy Officer or designee.

(10) The Privacy Act of 1974 contains provisions for the amendment or correction of a medical record. In order to effect this requirement in CPRS, the Privacy Act Officer or designee will be provided a security key to access the computer-based record for purposes of amending or correcting the record.

(11) All staff members who, by virtue of their position description, functional statement, statement of work, affiliation agreement, sharing agreement, or scope of practice when providing patient care are authorized to document care in the medical record.

(12) Medical records must, at all times, be immediately available for patient care. Paper medical records charged out of the medical center file room must be kept in a highly visible but secure location. They will not be stored in a desk drawer or locked cabinet.

(13) Computer screens will be turned so that a passerby may not easily read the screen. Individuals will not share computer access codes. When individuals are finished entering into the electronic record, they must make sure that they have discontinued access to Veterans Health Information System and Technology Architecture (VISTA); thus eliminating unauthorized access to patient information.

(14) Clinicians should refrain from re-entry of previously entered or captured data, such as cut and paste in CPRS or inserting copies into paper record. Avoidance of these practices ensures conveyance of most recent data, maintains record flow in an accurate contiguous manner, and facilitates accurate and safe utilization of record by all clinicians.

b. Downtime: When VISTA is down, refer to Policy Memorandum Number IRM-07, AIS Contingency Planning, August 4, 2011.

(1) Progress notes and consults may be handwritten then scanned into CPRS.

(2) Patient data will be available from contingency health summaries that contain predetermined information.

c. Amendment of Medical Records:

(1) Electronic documentation (i.e., progress notes, discharge summary, etc.) may be amended at any time by the author or an expected co-signer prior to authentication.

(2) Once a document has been authenticated, amendment is accomplished by creation of an addendum to the original document rather than a new computerized document.

(3) If a progress note is put under the wrong patient's name:

(a) Unsigned Notes: The author should use the copy action to copy the text under the correct patient's name, then go back to the unsigned incorrect note and "delete."

(b) Signed Notes: Copy the text to the correct patient's name. Go back to the incorrect original note and choose the "Make Addendum" command to add text indicating note was done by author in error. Send e-mail in VISTA to G.CAC with the following information: patient's name, full SSN #, note title, date/time of note, author, and reason for error. Remember: Do not place the patient's name and SSN within the title of your e-mail but within the body of your text only. A Clinical Application Coordinator (CAC) will then change the title, so that no one will be able to view it, to "ERRONEOUS NOTE."

(4) When a patient requests amendment of documents in his/her medical record, whether electronically generated or handwritten, the request must be referred to the Chief or Assistant Chief of Health Information Management.

(5) When original electronic documentation requires correction or amendment, the provisions of the Privacy Act of 1974, which apply to the correction or amendment of the original hard copy medical record, will be applied.

d. Medical Alert: When there is a history of allergies, adverse reactions or other conditions which, in the physician's opinion, merits special attention, the allergy and adverse reaction information will be entered in VISTA for access under the "Patient Health Summary" and "Patient Inquiry." It can also be viewed in CPRS in the top right corner of every tab in the Patient Posting box and on the Cover Sheet.

e. Problem List: The problem list should contain all established diagnoses, which are relevant to the patient's health care. Entries other than diagnosis, if significant for the health care team's information, may be recorded on the problem list. In the electronic medical record, the problem list will be initiated for every ambulatory patient by the third visit by the treating clinician. An entry on the problem list is the overall responsibility of the primary care provider. As new medical diagnoses and conditions are added, resolved problems will be inactivated. A status of active or inactive will be assigned to each problem when entered or edited. Historic problems will be identified in the comment section as "Historic" and include the patient's description of the date of onset. The immediacy of each problem will be identified as "chronic" or "acute."

f. History and Physical Examination:

(1) A complete inpatient admission history and physical (H&P) examination will be performed within 24 hours of admission and signed by a physician on acute inpatient care units. In long term care (CLC), H&P will be performed within 48 hours. If the H&P is performed by a physician assistant, nurse practitioner, or house staff, an attending physician may countersign or write a separate progress note or addendum that signifies concurrence of the H&P, assessment and plan. Qualified oral surgeons may complete the history and physical examination of dental and oral surgery patients admitted to Dental Service. Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry. Only one dictated H&P is allowed for inpatient stay.

Note: VA Form 10-10M, Medical Certificate may qualify as the admission progress note when prepared on the day of admission or immediately prior to admission (VA Handbook, 1907.1, Section 8, m (2) (a).

(2) When, within a 30-day period, a patient is readmitted, the previous history and physical examination may be used if it is professionally determined that such an examination in conjunction with the prior examination is adequate to reflect a comprehensive current physical assessment. In this case, an interval note will be written and will indicate that the previous H&P has been reviewed and will note pertinent changes or lack thereof. An interval note is not required if the H&P was conducted within seven days of admission. The initial H&P will not be moved forward, but will remain with the original period of hospitalization.

(3) When an inpatient has been hospitalized a year or longer, an annual physical examination will be required and will be completed electronically by the attending provider.

(4) As an integral part of the evaluation of all admissions, an oral examination will be completed and recorded on the oral-maxillofacial database for those patients in whom dental intervention is perceived as a necessary and an integral component of treatment.

(5) When a patient is first admitted to VA care on an ambulatory and/or outpatient care level, a relevant history of the illness or injury and physical findings will be documented in the patient record. The provider doing the exam must document the history and physical exam.

(6) If a patient is on ambulatory outpatient care status for a year, at the time of the next visit the patient will be given an annual physical or mental status examination, or as applicable, an assessment of the condition for which care is authorized. An assessment as to whether continued care on an ambulatory or outpatient basis is required, and will be documented following the diagnosis.

g. Interdisciplinary Treatment Plan:

(1) An initial treatment plan, documented by the licensed independent practitioner as part of the physical examination will be established on all patients within 48 hours of admission on acute inpatient care units. Treatment plans should specify the diagnostic and therapeutic activities that will be undertaken in regard to each of the patient problems and the specific staff members responsible for carrying out these activities, if other than the author. A discharge plan should also be a component of the treatment plan. Revisions will be undertaken as necessary.

(2) Each inpatient record will contain a nursing admission assessment within eight (8) hours of admission.

(3) Community Living Center (CLC) providers must have the initial treatment plan documented within 14 days of admission; a plan of care is developed no later than 1 week (7 days or less) after the initial assessment, i.e., within a total of 21 days after admission the care is planned and coordinated in a collaborative approach. Care plan goals are documented and the patient's response to care is evaluated when there is a significant change in condition, or at least every 90 days for extended care patients.

h. Laboratory and Imaging Reports:

(1) Order entry for laboratory tests shall be completed in full; clearly identifying: patient, location, requester, test date and special handling. Only authorized individuals (as defined by their privileges or scope of practice) will enter requests for laboratory tests.

(2) Requests for tissue examination must contain the preoperative diagnosis and a brief clinical history, which includes the reason for the examination.

(3) Requests for imaging services must be entered electronically and contain a complete reason for the exam.

(4) Signature, initials, or electronic signature must authenticate all reports.

(5) Reports of nuclear medicine tests are entered electronically. They will reflect identity, date, amount of radiopharmaceutical agents used, and specific preparation of the patient and findings.

i. Progress Notes:

(1) Every episode of clinical care will be documented by the respective clinical staff as defined by their privileges or scope of practice in a progress note. The admission progress note will include the type of admission (i.e. elective, emergency), chief complaint, a brief summary of the patient's condition, references to any previous related admissions and a tentative diagnosis.

(2) Progress notes will be entered into CPRS, whenever possible, by Medical Staff, House Staff, Registered Nurses, Licensed Practical Nurses, Rehabilitative Medicine Therapists, Dietitians, Social Workers, Psychologists, Pharmacists, Clinical Technicians and other qualified members of the health care team to facilitate a multidisciplinary cooperation and approach to care. Progress notes must be dated and identified by the name and profession of the individual making the entry. Supervising Staff Physician must document supervision by annotating in a Progress Note for Residents.

(3) Progress notes will give a pertinent chronological report of the patient's course, changes in condition, response to medications and plans for the results of treatment particularly relative to diagnostic assessment and therapeutic efforts.

(4) When a patient is transferred between specialties, an inter-service transfer note will be entered in the electronic medical record which will give a concrete recapitulation of the hospital course to date, include the indications for the transfer, and be developed to assist the receiving unit. This note will be documented prior to the patient's transfer. Transfer summaries will be dictated between services (Medical, Surgical and Psychiatry) for any length of stay within that service greater than three days. Nursing transfer notes will be documented by the transferring and receiving units and shall note the patient's response to care and status.

(5) Frequency of Attending Staff Progress Notes:

(a) Initial note no later than the day after admission.

(b) Daily for patients within an Intensive Care Unit.

(c) Weekly (once every seven calendar days) for acute care hospitalization or more frequently based on patient's change in condition.

(d) Monthly (once every 30 days) for extended care hospitalization (CLC).

j. Discharge Progress Notes/Discharge Instructions/Discharge Summary:

(1) A discharge progress note will be completed for each period of hospitalization. This note will contain date and type of discharge, diagnoses, discharge medications, recommendations relative to diet, exercise, limit of disability, condition on discharge (to include character of surgical wound, if appropriate), place of disposition, recommendations for follow-up and patient education. A copy of the discharge instructions will be given to the patient and/or significant other. A formal (dictated) narrative summary does not substitute for a discharge progress note. Per Medical Staff Bylaws and Rules and Regulations, responsibility for preparation of Discharge Summary and contents rests exclusively with member of medical staff having primary care

responsibility for the patient for the patient. Treating specialty from which patient is discharged is responsible for completing Discharge Summary.

(2) When preprinted instructions are given to the patient or designee, the record should so indicate.

(3) In cases involving death, the time and date when the patient expired, and the events leading to the death must be recorded by the 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. The deceased shall be pronounced dead by a physician.

(4) See also Appendix A, Hospital Summary.

k. Supervision of House Staff: 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/primary care physician. The frequency of such notes shall be determined by the nature of the patient's condition, the likelihood of changes in the treatment plan, and the complexity of the care and experience of the trainee being supervised. For example, the attending/primary care physician will place appropriate documentation in the patient's medical record no later than the day after admission, at the time of any significant change in the clinical course or therapeutic plan, or prior to any invasive procedure.

l. Consultations:

(1) Consultation requests will be entered electronically by the service requesting the consultation. The request will include a brief description of the patient's condition, reason for the consultation, other information of value (such as medication which may affect the condition being evaluated) and the electronic signature of the requesting physician, dentist, podiatrist, or other allied healthcare professionals within their scope of practice.

(2) The consultation report will contain an electronically entered opinion by the consultant (based on examination of the patient and his/her record), date of the consult and electronic signature.

(3) Consultations should be performed as soon as possible following the request, to ensure proper treatment of the patient and to prevent prolongation of hospital stay. Emergency consultations should be requested as a "stat consultation". These consultations should be completed as soon as possible depending on urgency. If the consult has been cancelled, it needs to be closed out in the consult tracking system.

(4) Any consultations performed by a nurse practitioner or physician assistant must be co-signed by a staff physician. Enterostomal consults do not require co-signature.

m. Behavioral Health Special Treatment Procedures: In Behavioral Health, special justification and documentation is required for the use of:

(1) Electro-convulsive and other forms of convulsive therapy.

(2) Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental, or behavioral disorder.

(3) Behavior modification procedures that use aversive conditioning.

n. Anesthesia:

(1) A pre-anesthesia evaluation will be completed by the Anesthesiologist or providers who administer moderate sedation, who will document pertinent information relative to choice of anesthesia (i.e., general, spinal, regional, etc.), surgical procedure anticipated, previous drug history, other anesthetic experiences and any potential anesthetic problems.

(2) A post-anesthesia note will be written by the Anesthesiologist and will include the patient's level of consciousness on entering and leaving the recovery room, vital signs and when used, the status of infusions, surgical dressings, tubes, catheters, and drains. The medical record will document the name of the licensed practitioner responsible for the patient's release from the recovery room or clearly document the discharge criteria used to determine release.

o. Operations:

(1) Medical records will document all aspects of a surgical patient's preoperative, operative and postoperative care. The record will contain preoperative diagnosis, a complete description of the surgical procedure and findings, the names of all the practitioners involved in the patient's care, the postoperative course, evidence of the patient's readiness for discharge from the post anesthesia care, and details of the discharge.

(2) All procedures requiring anesthesia and/or conscious sedation will require a preoperative and postoperative assessment note by the staff practitioner or resident. Staff practitioners will be responsible for authorizing the performance of such procedures, and such procedures should only be performed with the explicit approval of the staff practitioner.

(3) An operative report will be fully dictated by the operating practitioner immediately after surgery before the patient is transferred to the next level of care. The report will be carefully read and signed by the supervising practitioner. It should contain the indication for the procedure, operative findings, the technical procedure used, specimens removed, estimated blood loss, postoperative diagnosis and the names of the attending surgeon, primary surgeon and assistants.

(4) Postoperative documentation will include: vital signs and level of consciousness, medications and blood and blood components, any unusual events or postoperative complications, including blood transfusion reactions, and the management of such events.

(5) Detailed reports of diagnostic and therapeutic procedures not performed in the operating room will be documented in the progress notes and will contain: name of procedure, person performing procedure, details of performance, major findings and conclusions, whether or not tissue was removed, any complications, signature, title, and date.

(6) The responsible nurse that was present during the surgery will enter the Nurse Intra-Operative Circulating Report into the computer. A hard copy will be printed and signed for the paper record. The Recovery Room nursing care will be documented on the Recovery Room record.

(7) When the procedural evaluation is completed as part of an outpatient preadmission process, the staff practitioner's pre-procedural note in the outpatient's record, or on a preadmission form, may be regarded as valid for a period of 30 days for patients with stable diseases or conditions, or undergoing elective procedures.

p. Informed Consent: All patient records will include evidence of informed consent for any procedure, treatment, research/experimental protocol and investigational drug series for which it is appropriate. Informed consent will be obtained in accordance with VHA Handbook 1605.1 Privacy and Release of Information, VHA Handbook 1004.01, and current The Joint Commission regulations and VISN policies.

q. Doctors Orders:

(1) All orders for treatment will be documented appropriately, wherever possible, utilizing the order/entry capabilities of VISTA. Medical students may write and sign orders; provided a physician/dentist immediately countersigns the orders. All orders must contain the date and time the order was written with the name of the practitioner placing the order signature. The attending physician/dentist is responsible for any unsigned orders.

(2) Medications must be identified as to name, strength, route of administration, frequency and the conditions under which medications shall be given. Through CPRS, the responsible physician/dentist will enter the orders.

(3) There shall be an automatic stop order for all narcotics, antibiotics, and anticoagulants, unless the physician's/dentist's order for such a drug reflects a definitive number of doses or a specific period of time the drug is to be administered. No stop orders will be exercised without communication with the physician/dentist.

(4) Medication orders must be reviewed and rewritten following surgical procedures, which require general anesthesia, when a patient is transferred between services/specialties or is transferred to a critical care unit.

(5) Verbal orders must be authenticated by a physician's signature including date and time the order is signed. Nurse practitioners and physician assistants may write orders according to their particular privileges or scope of practice. Countersignature is also dictated by their privileges or scope of practice. Verbal orders may be accepted by licensed pharmacists, registered nurses, staff respiratory therapists, registered dietitians, physical therapists, and occupational therapists. The nature of the order (policy, verbal, or telephonic) must also be documented. Please refer to Policy Memorandum No. COS/11-93, Verbal/Telephonic Diagnostic and Therapeutic Orders.

(6) An order must be written to admit, to discharge, or to transfer a patient between wards, or between services, or between Medical Staff members.

(7) On Long Term Care programs, orders will be reviewed monthly and rewritten quarterly. The monthly review may be documented by simply writing "continue" or "renew" provided no changes are made to the orders in the paper record or CPRS.

(8) Use of seclusion and restraint is done according to Policy Memorandum 11-71 "Restraint and Seclusion."

(9) Medications administered in error and adverse drug reactions shall be documented and reported to the physician.

(10) Upon physician authentication (signature) of the order, VISTA software will automatically print a copy of the Doctor's Orders on a printer reserved for medical record documents on the ward.

(11) An order must be written to admit a patient to an Observation Stay. The order must state "Admit to Observation" or "Admit to OBS." The medical necessity for the observation stay must be clearly documented.

(12) Standing Orders will exist to permit qualified professional nurses in the Critical Care areas to meet patient needs in emergencies. Standing orders are implemented pending the arrival of the physician, and consist of prescribed medications and treatments necessitated by life-threatening changes in patient.

r. Respiratory: Orders for respiratory care shall specify the type, frequency and duration of treatment, any medications, the type of diluents, oxygen concentration and the diagnosis. All administered therapy shall be recorded and include: type, date and time, effects, any adverse reactions and patient instructions. The need for long-term oxygen therapy shall be adequately documented, preferably based on arterial blood gas results.

s. Do Not Resuscitate (DNR):

(1) The DNR order in the patient's medical record must be written by the attending physician or by the medical or surgical resident, co-signed by the attending physician. Nurses **MAY NOT** take verbal orders for DNR.

(2) DNR orders are not subject to renewal, and are considered to be in effect indefinitely for the duration of the current admission, unless specifically revoked by the responsible physician. An accompanying progress note will include, at a minimum, diagnosis, prognosis, patient's wishes when known, family wishes, and consensual decision and recommendations of the treating team. The note should include appropriate dates and times and any applicable documentation of "informed consent" or patient's wishes for confidentiality from family. The attending physician will be the only one to enter the note in the patient's record.

t. Advance Directive: If the patient completes an advance directive, a copy will be scanned in the medical record. The ward or clinic's staff will be responsible for placing an Alert Progress Note in the patient's electronic medical record.

u. Autopsies: Preliminary or provisional anatomical diagnoses will be documented within 72 hours. Final protocols will be completed, signed and properly filed within 30 days in routine cases, or three (3) months in complicated cases.

v. Adjudication: When requested for adjudication purposes, a 21-day certificate will be completed and will list the diagnosis responsible for the patient's inpatient stay. The discharge summary should indicate the patient's competency to handle VA funds.

w. Photographs: The medical record will document the taking of any pictures, films, etc., by written consent. All media are considered part of the medical record and therefore subject to the Privacy Act and all other confidentiality regulations. This applies to all media whether taken by Medical Media or other staff members.

x. Home Based Primary Care (HBPC):

(1) There shall be a written plan of care for all hospital based primary care patients that is updated no less than every 60 days and contains:

(a) All pertinent diagnoses;

(b) Prognosis including short and long-term objectives;

(c) Type and frequency of service required;

(d) Functional limitations of patient and activities permitted;

(e) Required safety measures; and

(f) Sociopsychological needs

(2) The following additional information will be recorded:

(a) Designation of primary care physicians;

(b) Household composition including person assuming responsibility for care;

(c) Suitability of residence for provision of care;

(d) Progress Note for each visit; and

(e) Summary.

5. **RESPONSIBILITIES**:

a. The Medical Center Director and Chief of Staff Members are responsible for ensuring that processes are in place for the use of not only the paper Consolidated Health Record (CHR) but the Computerized Patient Record System (CPRS) and that these processes are available and functional in a timely and accurate fashion. Data entry may be accomplished by various methods depending on the state of electronic evolution, finances, staffing levels, etc.

b. Health Information Management Services staff are responsible for tracking and monitoring issues as they relate to patient medical record documents, paper and electronic. Health Information Management Services (HIMS) staff members have continued responsibility for the amendment of documents that have been entered in error. It is the responsibility of the Health Information Management Services to ensure that medical records of patients are available for patient treatment, are properly completed, and maintained in compliance with standards established by VHA Headquarters and this medical center.

c. Clinical Informatics is responsible for ensuring that software package parameters are set up in such a way as to facilitate ease and accuracy of documentation for the end user. Clinical Application Coordinators are responsible for coordinating and assuring the necessary training is provided to all staff entering and gathering patient information.

d. All medical center staff who utilizes CPRS is responsible for maintaining, improving, and advancing their electronic skill levels. Employees are responsible for ensuring that documentation gathered and entered by them is accurate, appropriate and completed in a timely fashion. They are responsible for reporting any discrepancies, identified problems, etc. All staff members are responsible for following security and confidentiality standards described by the Network/Local security and confidentiality policies.

e. It is the responsibility of the clinical staff to document evidence of the patient's medical evaluation, treatment and change in conditions during the patient's hospitalization, or during an outpatient or emergency visit to the medical center.

6. **REFERENCES**:

a. VHA Handbook 1907.1, Health Information Management and Health Records, dated September 9, 2012;

b. VHA Handbook 1605.1, Privacy and Release of Information, dated May 17, 2006;

c. Research, dated May 2, 2012,

d. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009;

e. RCS 10-1, March 2011.;

f. The Joint Commission, accreditation manual, current edition

g. VA Medical Center Bylaws and Rules and Regulation, most current edition.

h. Policy Memorandum Number COS11-71, Restraint and Seclusion – Special Interventions, dated August 13, 2013;

i. Policy Memorandum Number IRM -07, AIS Contingency Planning dated 8/4/2011;

j. Policy Memorandum Number IRM-12, Electronic Mail (E-Mail) dated 7/25/2011;

k. Policy Memorandum Number PO-01 Privacy Policy, December 4, 2013;

l. Policy Memorandum Number COS 11-93, Verbal/Telephonic Diagnostic and Therapeutic Orders, May15, 2010;

m. Stedman's Medical Dictionary.

n. CEB Minutes of 5/10/2000

7. **RESCISSIONS**: Policy Memorandum No. HIMS-1, dated December 1, 2011.

8. **ATTACHMENTS**:

Appendix A - Hospital Summary

Appendix B - Physician Quick Reference

Appendix C - Correction To Medical Record Documentation

Appendix D - Development of New Overprinted Forms

Appendix E - Protection of Medical Records from Water Damage

9. **EXPIRATION DATE**: February 10, 2017

//Original signature on file

SHARON M. HELMAN, MBA, VHA-CM
Medical Center Director

HOSPITAL SUMMARY

1. The hospital summary will be used to document a patient's discharge from the medical center, transfers to other levels of care such as VHA Domiciliary care, VHA Nursing Home, or other VA Medical Centers.

2. The hospital summary shall be entered into the patient's record within a reasonable period of time, not to exceed thirty (30) days following discharge. Practitioners failing their obligations for timely health record completion will be notified concerning their delinquent health record. If the health record is not completed in a timely manner, discipline will begin in succeeding steps from verbal counseling through to suspension if needed. The staff physician is responsible for nurse practitioners and physician assistants' time completion of health records.

3. The attending physician will review the summary, make appropriate edits and indicate approval by signature. If not the author, the attending staff physician, dentist, podiatrist, or Service Chief must review the summary, make appropriate edits, and indicate approval by signature.

4. To promote continuity of care, the physician will dictate the summary prior to transfer between the hospital and the Community Living Center (CLC), or any transfers to other levels of care..

5. Summaries will be prepared as follows:

a. Diagnosis: List the principal diagnosis (i.e., that condition established after study to be chiefly responsible for the admission of the patient to the hospital for care) then, in order of clinical importance, list all other diagnoses for which treatment was given. Diagnoses will include post-operative complications or infections and drug or serum reactions. All diagnoses should include a site and etiology, when applicable, and will be stated in accordance with the latest edition of International Classifications of Diseases Coding Manual (ICD-9). Diagnoses will be stated in full without symbols/abbreviations.

b. Psychiatric Diagnoses: Psychiatric diagnoses will be limited to conditions under treatment or to active conditions previously diagnosed and will be included only when they directly affect the patient's condition, medical care, or length of stay. Such diagnoses will be stated in accordance with the latest edition of Diagnostic and Statistical Manual of Mental Disorders.

c. Observation and Examination Cases: The medical staff is responsible for observation and examination cases and will record findings adequate for both professional use and adjudication purposes. Diagnoses appearing on the Hospital Summary must reflect the condition for which the patient was observed.

6. Operations: The latest edition of current Procedural Index will be used for recording operations and surgical procedures, which will be stated in full without symbols or abbreviations. The site involved and the procedures performed will be stated. The listing will include all operations, diagnostic and therapeutic procedures and the date performed. All procedures should be documented in the text of the summary.

7. Narrative Summary will include:

a. Reason for admission (Principal diagnosis – The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital).

b. Pertinent past history.

c. Pertinent points in review of systems (including allergies or drug sensitivities).

d. Pertinent findings of laboratory and radiological data.

e. Pertinent findings of physical examination, particularly abnormalities.

f. Brief course in hospital stay to include treatment received, surgeries performed, and condition on discharge. Condition must be more specific than "improved" and should permit measurable comparison with condition on admission.

g. Condition of wound, if applicable.

h. Place of disposition, i.e., home, nursing home, etc.

i. Discharge instructions to patient or responsible other to include:

(1) Information regarding condition or proper home care.

(2) Medical follow-up, if private physician, state name if possible.

(3) Medications on discharge.

(4) Diet instructions.

(5) Specific date to return to work, or if retired, or to be determined at a later date, please state.

j. If the patient has a psychosis or an organic mental impairment, there must also be a statement regarding competency to handle VA funds. The patient's functional assessment according to GAF rating scale should also be included with diagnostic and "Axis assignment."

CLINICIAN DOCUMENTATION QUICK REFERENCE

Document	Timeliness of Completion	Documentation Components Required
Outpatient Visit	Immediately following visit	- Will include date and clinic title, vital signs, chief complaint, relevant history of illness or injury, clinical observations, results of treatment, reports of tests, procedures performed, doctors orders for medication, tests, therapy, work/activity limitations if any, diet, follow-up instructions, level of understanding and signature and title of provider.
Problem List	Initiated by third ambulatory visit. Required on all inpatient stays.	Initiated by the third visit and will contain: 1. Known significant diagnosis; 2. Procedures performed; 3. Drug Allergies; 4. Adverse Reactions.
History and Physical	Within 24 hours of admission.	Will be completed within 24 hours of admission for acute medical and 48 hours for CLC. On patients readmitted within 30 days, an interval H&P will suffice as long as it is professionally determined that such an exam, in conjunction with the prior examination, is adequate to reflect a comprehensive current physical assessment.
Assessment Treatment Plan	Within 48 hours of admission 14 days for CLC 21 days for CLC care plan	Physician will establish initial treatment plan on all patients within 24 hours as part of physical exam. Will address diagnostic and therapeutic plans for each problem, patient education, and discharge plans. - Nursing assessment within 8 hours of admission.
Laboratory and Radiology Reports	As needed.	Tissue Exams must contain the preoperative diagnosis and a brief clinical history, including reason for the exam. - Radiology request must state reason for the exam.
Nuclear Medicine	As needed	- Will reflect identity, date, amount of radiopharmaceutical agents used, and any specific preparation of the patient and findings.
Progress Notes	Immediately following ambulatory visit. Frequency of inpatient depends largely on the	Will give pertinent chronological report of the patient's course, changes in condition, response to medications and plans for the results of treatment particularly relative to diagnostic assessment and therapeutic efforts. - Inter-service transfer note will give a concrete recapitulation of the hospital course to date, including the

Document	Timeliness of Completion	Documentation Components Required
	complexity of the patient, competency of staff, etc.	indications for the transfer, and be developed to assist the receiving unit.
Discharge Progress Notes/ Instruction/ Discharge Summary	Prior to discharge	Will contain type of discharge, diagnoses, discharge medications, recommendations relative to diet, exercise, limit of disability, condition on discharge, place of disposition, recommendations for follow up and patient education. Copy given to patient or designee. - Death cases will include time and date when patient expired, and the events leading to the death must be recorded by the physician.
Consults	Performed as soon as possible following the request.	Will include a brief description of the patient's condition, reason for the consultation, other information of value (such as medication which may affect the condition being evaluated) and signature of requesting physician. - Emergency consults will be requested as "stat" and completed as soon as possible depending on the urgency.
Anesthesia	Immediately before or after procedure.	Pre-anesthesia notes will document pertinent information relevant to the choice of anesthesia, surgical procedure anticipated, previous drug history, other anesthetic experiences and any potential anesthetic problems. - Post-anesthesia notes will document level of consciousness on entering and leaving the recovery room, vital signs and when used, the status of infusions, surgical dressings, tubes, catheters, and drains. Also, the name of the licensed practitioner who released the patient from the recovery area or the specific criteria used to determine the release.
Operative Notes and Reports	Immediately following procedure or surgical episode	Will contain preoperative diagnosis, a complete description of the surgical procedure and findings, the names of all the practitioners involved in the patient's care, the postoperative course, evidence of the patient's readiness for discharge from postanesthesia care, and details of the discharge. An operative report will contain the indication for the procedure, operative findings, the technical procedure used, specimens removed, postoperative diagnosis and the names of the attending surgeon, primary surgeon and assistants. A postoperative note will include: vital signs and level of consciousness, medications and blood and blood

Document	Timeliness of Completion	Documentation Components Required
		components, any unusual events or postoperative complications, including blood transfusion reactions, and the management of such events. Will be entered in all cases where there is a filing or transcription delay in order to provide pertinent information for use by any practitioner who must attend the patient.
Dr's Orders	As needed. Discharge order before patient is discharged.	Orders for medications should include name, strength, route of administration and frequency. Medication orders will be reviewed and renewed following any surgical procedure requiring general anesthesia. Verbal orders will be authenticated by a physician's signature including date and time the order is signed. CLC orders will be reviewed monthly. Nurse practitioners and physician assistants will write orders in accordance with their scope of practice. PRN orders may not be used for restraint and seclusion.
DNR Order	As needed.	Must be written by the attending physician. Nurses may not take verbal orders for DNR. Accompanying progress note done by physician will include diagnosis, prognosis, patient's wishes when known, family wishes, and consensual decision and recommendations of the treatment team.
Autopsies	Provisional within 72 hours, final 30 days.	Preliminary or provisional report within 72 hours. Final filed within 30 days, or 90 if complicated case.

CORRECTION TO MEDICAL RECORD DOCUMENTATION

ELECTRONIC RECORD:

a. All clinicians should review computerized patient records before affixing their electronic signature to a document to assure information is correct. Notes are occasionally entered into VISTA by practitioners for the wrong patient, wrong clinic visits, etc. These notes should be addendum immediately upon discovery with directions to the viewer to disregard their contents.

b. To further prevent the ensuing provision of patient care by other practitioners based on erroneously entered clinical information, the notes will be retracted from active view. To preserve the clinical record in full, erroneously entered notes will NOT BE DELETED from VISTA.

c. The author may copy the note into the correct patient's record or re-enter it.

d. The author will amend the note with information identifying it as erroneously entered and directing the viewer to disregard its contents.

e. The author will notify the Clinical Application Coordinators by sending an e-mail message in VISTA to G.CAC or utilize the CAC communication tool in CPRS. For accurate identification of the note requiring action, the message must contain:

(1) Name of patient under whom the note was entered,

(2) Last four of patient's SSN,

(3) Full progress note title of the erroneously entered note,

(4) Date and time of the erroneously entered note,

(5) Author, if other than the message sender, and

(6) Reason note is to be removed from view.

f. The Clinical Application Coordinators, upon noting documentation is present, indicating that note is erroneous, will retract the note.

g. The title, body of the note, the author and date and time note was created will remain unchanged but will be removed from active view by VISTA users.

DEVELOPMENT OF NEW/REVISED OVERPRINTED FORMS/TEMPLATES

1. The initiating department will prepare a sample form for approval by the Chair or Assistant Administrator of that department and obtain concurrence by the Chair or Assistant Administrator of any other department involved in the completion of new form.

2. Approval/concurrence signifies the intent of the overprinted form is clear, can be implemented, does not conflict with accepted practice of their discipline, and is in keeping with the accepted standards.

3. The form, documentation of concurrence, and completed Reproduction Request (VA Form 3011), will be forwarded to the Administrator, Informatics Services (IS) for compliance review and approval in conjunction with Health Information Management Department (HAS/HIMD). If this is a revision of a prior existing form, a copy of the old form must also be included.

4. The Chair or Assistant Administrator will assess form for inclusion as a computerized form in CPRS and ensure that such a form does not already exist. If appropriate, the requesting department will be contacted when the form is activated in CPRS.

5. Forms that cannot be computerized will be forwarded to Office Operations Section (HAS/136C2) for reproduction authorization and assignment of a form number.

6. If the overprint is deemed inappropriate, or a duplication of an existing form, the individual submitting the request will be contacted by Health Information Management Department personnel for resolution.

PROTECTION OF MEDICAL RECORDS FROM WATER DAMAGE

Paper medical records may be subjected to widespread or localized damage from rising water, as in the case of flood or broken water mains, or falling water, such as from leaking or broken pipes or fire sprinkler activation. Following such an emergency, water-damaged records require special attention to restore them to their original state. Even though it is the policy of this medical center to maintain medical records in such a way as to prevent any form of water damage, this appendix details procedure to follow in the event of such an occurrence.

PROCEDURE:

a. Rising Water: Widespread damage may be caused to medical records housed on the ground level due to flooding during or following extreme rain conditions or broken water mains.

(1) Medical records will be maintained in an area that is unlikely to flood or be subjected to damage from water.

(2) Upon notification that it is likely that the surrounding vicinity will be subject to flooding, and the medical record file room is likely to be flooded:

(a) All efforts within human possibility will be made to move records to an area that is unlikely to be subjected to water damage. Personnel will not be subjected to conditions that would expose them to danger to their life or health.

(b) All electronic equipment will be turned off. Equipment will be moved to a dry location that is unlikely to be affected by water damage.

(c) To protect the confidentiality of medical records during a flooding crisis, the area will be secured and only authorized personnel will have access to the area.

(d) Floodwaters are often mixed with sewage, animal waste, fertilizers and/or industrial waste, and should be considered a biohazard. Employees will not be allowed to re-enter the flooded area until all freestanding water has been removed and the area is thoroughly cleaned by the Environmental Management Department.

b. Falling Water: Widespread or localized damage may be caused to medical records due to a leaking or burst pipe or malfunctioning fire sprinkler.

(1) Paper medical records will be maintained in file shelving units that have a canopy top. Paper medical records will not be stored on top of filing cabinets or on the floor.

(2) Upon notification of a leak or malfunctioning fire sprinkler:

(a) Shelving units in danger will be covered with plastic. A supply of plastic sheeting will be obtained from the Engineering Department. After the threat of water damage has passed, all plastic will be removed.

(b) Computer equipment and any other machinery or furniture may also be covered with plastic to minimize damage, as time permits after the threat to medical records has been minimized.

(c) Environmental Management Department will be contacted to supply appropriate receptacles to catch water, absorbent materials to soak up water, vacuum water, and thoroughly clean and dry the affected area.

c. Recovery/Restoration: Should paper medical records sustain water damage; a quick response will be required to recover their contents intact. Paper records left wet for any significant length of time are at risk of unrecoverable damage due to disintegration, tearing, smearing, or mildew/mold growth. Depending on the volume of records involved, full recovery may be realized with a local effort only, or may require more extensive measures, such as a contract with a water damage restoration company.

(1) If a small quantity of records is wet from a clean water source, authorized personnel must respond immediately to:

(a) Carefully remove the records from the shelves and gently pat dry as much as possible;

(b) In a secure location, separate each record on a clean, dry, flat surface for the paper to thoroughly dry;

(c) Print any electronic documentation that may be required to reconstruct damaged pages;

(d) Reassemble each record in the approved filing sequence;

(e) Thoroughly dry the file shelves; and

(f) Replace the records on the shelves in the correct terminal digit order.

(2) If a large quantity of records is wet or if the water source may be contaminated, such as in the case of flood water:

(a) A water damage restoration company should be contacted immediately upon discovering the damage and an emergency purchase order be secured for their services.

(b) Any contract for water damage restoration services should specify the method of recovery, the time that will elapse between acquisition and return of the records, and safeguards against breaches in confidentiality.