DEPARTMENT OF VETERANS AFFAIRS (VA)
SALT LAKE CITY HEALTH CARE SYSTEM
Salt Lake City, Utah

MEMORANDUM 11.05 8/3/2018

MEDICAL RECORD COMPLETION POLICY

1. PURPOSE:

This policy defines the standards for completion of medical records by physicians and other caregivers and policies for failure to comply. This policy references Department of Veterans Affairs policies and local station policies that may provide additional details.

2. POLICIES:

a. Discharge Summaries. Timely completion of summaries is mandated in the Medical Staff Bylaws. The treating specialty that the patient is discharged from is responsible for dictating the summary. The resident shall dictate a discharge summary within 24 hours of hospital discharge. All summaries delinquent over 96 hours will be reassigned to the responsible Chief Resident for dictation. The resident and attending physician shall authenticate the discharge summary as soon as possible following dictation and transcription (Medical Staff Bylaws). Attending physicians are required to co-sign summaries within two weeks of dictation. If still not co-signed after three weeks, the summary will be reassigned to the appropriate service chief for that specialty. If still not co-signed after four weeks, the summary will be reassigned to the Chief of Staff. The Chief of Staff's Office will then contact the attending physician to schedule a counseling and signature session. The discharge summary shall include:

(1) Principal diagnosis

(2) Other diagnoses/conditions treated

(3) Pertinent diagnoses noted but not treated

(4) All operations and procedures performed and treatment rendered during current admission, with dates

(5) Chief complaint/reason for hospitalization

(6) Brief synopsis of admitting history and physical

(7) Lab data/special findings

(8) Hospital course, including principal diagnosis, surgical procedures, other major problems, treatment and response

(9) Disposition, including condition at release, physical activities/limitations (including return to work statement), period of convalescence, competency opinion (when required)

(10) Medications at discharge

(11) Diet instructions

(12) Recommendations for follow-up treatment, including date of next VA clinic visit

(13) Special instructions given to patient or family

(14) Name of nursing home or other receiving facility, private physician, etc.

b. History & Physical. All hospitalized patients shall have an admitting history, physical examination, assessment, and treatment plan written and authenticated by the responsible attending or resident physician within 24 hours of admission (Medical Staff Bylaws). Prior to surgery or any procedure requiring anesthesia services the medical history and physical examination must be completed no more than 30 days prior. In addition documentation of a review of the history and physical updating any changes in the patient's condition is required within 24 hours prior to procedure. (PC.01.02.03)

c. Attending Physician Admission Note. Within 24 hours of admission the attending physician shall examine the patient. The evaluation may occur before or after the admission. The attending physician will document in the medical record by either an independent progress note or an addendum to another progress note concurrence with or modifications, as needed, for the resident's initial diagnoses and treatment plan. The progress note must be properly signed and dated. The attending physician shall enter this progress note or addendum during the calendar day prior to the admission, on the day of admission, or the calendar day after admissions. (Center Policy Memorandum 11.10, "Supervision and Work Hours Limitation for Postgraduate Medical, Surgical, Dental, Optometry and Podiatry Residents").

d. Death Note. A summation statement (death note) shall be documented as a progress note. The death note will indicate the reason for admission, the findings and course in the hospital and the events leading to death. The death note does not replace the discharge summary (Center Policy Memorandum 04.40, "Medical Records").

e. Transfer Note. When patients are transferred between specialties (e.g., Medicine to Surgery, Mental Health to Medicine, etc.), a transfer note must be completed that summarizes the patient's course on that treating specialty. Final treating specialties may use these transfer notes to dictate a discharge summary covering the entire hospital course.

f. Informed Consent. Consent to a proposed procedure shall be noted in the medical record progress note (Center Policy Memorandum 11.24, "Patient Consent and Notification of Relatives"). Patients must also sign a standard consent form, SF-522, "Request for Administration of Anesthesia and for Performance of Operations and Other Procedures," for procedures and treatments requiring sedation, narcotic analgesia or anesthesia considered to produce considerable discomfort to the patient; having significant risk of complication or morbidity; requiring injections of any substance into joint space or body cavity and/or blood transfusions (Medical Staff Bylaws & Joint Commission). Appropriate informed consent includes information about the proposed treatment, benefits, risks, potential complications, alternatives, likelihood of success, and problems related to recovery (Joint Commission standards). Signed consents are valid for 60 days.

g. Nursing Assessment. An initial inpatient nursing assessment shall be documented in its entirety within 24 hours of admission (Joint Commission standards). Such assessments shall include (as indicated) the patient's learning needs, abilities, preferences, and readiness to learn. They should also consider cultural and religious practices, emotional barriers, desire and motivation to learn, physician and cognitive limitations, language barriers, financial implications of care choices, and patient's age. If the patient or family cannot provide information for the assessment, this fact must be noted. In the case of outpatients, nursing and members of other disciplines, as appropriate, will complete assessments during each visit (Center Policy Memorandum 11.07, "Patient and Family Health Education").

h. Seclusion and Restraint. Each episode of restraint use shall be documented in the patient's record. Any use of restraint is pursuant to an individual order or an approved clinical guideline (Center Policy Memorandum 00Q.60, "Seclusion and Restraint").

i. The Immediate Post Operative Note. The immediate post operative note will summarize the events, findings and outcome during the procedure. The note shall be entered into Computerized Patient Record System upon completion of surgery, before the patient is transferred to the next level of care.

j. Operative Report. An operative report shall be dictated within twenty-four hours from the completion of the surgery. The responsible surgeons (resident and attending) shall authenticate all operative reports within 7 days from the date of surgery. The operative report shall include, as applicable:

(1) Pre-op diagnosis

(2) Name of surgeon and all assistants

(3) Description of findings

(4) Procedures performed

(5) Blood Loss

(6) Specimen(s) removed

(7) Post-op diagnosis

k. Anesthesia. A pre-anesthesia assessment shall be documented. The patient is determined to be an appropriate candidate for anesthesia by a licensed practitioner. Anesthetic options and risks are discussed with the patient and family prior to administration. The pre-op plan for anesthesia is recorded. Prior to induction, the patient is re-evaluated for anesthesia. The physiological status is measured and assessed during anesthesia. The patient's status relative to post-anesthesia care discharge shall be documented in the medical record (Joint Commission standards). Postoperative monitoring and documentation of patients includes:

(1) Physiological status

(2) Mental status

(3) Intravenous fluids administered

(4) Medications administered

(5) Blood and blood components

(6) Impairments and functional status

(7) Pain intensity and quality

(8) Unusual events: post-op complications/management

l. Outpatient Records. These records shall include (Joint Commission standards):

(1) Patient identification (name and social security number)

(2) Primary care provider

(3) Chief complaint or reason for encounter

(4) Relevant history and physical exam

(5) Preventive disease indicators

(6) Diagnostic and therapeutic orders

(7) Clinical observations, including the results of treatment

(8) Diagnoses or impressions

(9) Patient disposition and any instructions given to the patient and/or significant other for care

(10) Referrals to other practitioners or providers of services within or outside the VHA

(11) Summary list (see paragraph m. below, "Summary List")

m. Emergency. Documentation requirements for patients treated in the Emergency Department shall include (Joint Commission standards):

(1) Emergency care provided to the patient prior to arrival, if any

(2) Time and means of patient's arrival

(3) Presenting complaints, signs and/or symptoms

(4) Reason for patients leaving against medical advice (AMA)

(5) Conclusions at the termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care

(6) Emergency patient transfers to other organizations include reason for transfer, stability of patient, acceptance by the receiving organization and responsibility during transfer

n. Summary List. For patients receiving continuing ambulatory care services, there shall be a list of the following (Joint Commission standards). This list must be started by the third visit. The Problem List feature in CPRS should be used to maintain the patient's significant diagnoses, conditions and procedures:

(1) Known significant medical diagnoses and conditions

(2) Known significant operative and invasive procedures

(3) Known adverse and allergic drug reactions

(4) Medications known to be prescribed for and/or used by the patient

o. Observation. The documentation requirements for 48-Hour Observation patients shall include (VHA Directive 98-025, "Recording Observation and/or Short Stay Patients"):

(1) Admission order

(2) History & Physical and assessment, including physical, mental and social assessment

(3) Treatment plan for Observation

(4) Reassessment within 23 hours: discharge patient to home or discharge and admit to an inpatient stay

(5) Discharge order

(6) Discharge note (CPRS or dictation), including final diagnosis, complications and comorbidities, reason for admission, outcome, follow-up plans, disposition and discharge instructions

p. Progress Notes. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. All practitioners make progress note entries. Wherever possible, each of the patient's clinical problems should be clearly identified in the note, and correlated with specific orders as well as results of tests and treatments. Progress notes by a physician shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problems.

q. Normal and critical test results (laboratory, pathology and radiology) must be reported to the patient within 7 days of receipt of test results for the outpatient and as soon as possible to the inpatient. Informing the patient must be documented in the medical record. (VA requirement). Note: For patients in the inpatient, emergency, or urgent care setting, it is not required or expected that each individual test result be communicated to the patient. The ordering practitioner or care team should strive to effectively communicate relevant information to the patient. (VHA Direction 2009-019)

r. Research, Clinical Trials and Experimentation. All consent forms related to research, experimentation, and/or clinical trials will include the name of the person who supplied the prospective participant with information and the date form was signed. Consent forms will address the participant's right to privacy, confidentiality and safety (Joint Commission standards). All patients asked to participate in a research project shall be given:

(1) A description of the expected benefits

(2) A description of potential discomforts

(3) A description of alternative services

(4) A full explanation of the procedures to be followed

(5) Assurance of the right to refuse to participate

s. Alcoholism and Other Drug Dependencies. Assessment of alcohol and drug dependencies shall include (Joint Commission standard):

(1) History of alcohol, nicotine, and other drug use

(2) Types of previous treatment and responses

(3) History of mental, emotional, and behavioral problems

(4) History of biomedical complications associated with alcohol, nicotine, or other drug use

(5) Psychosocial assessment

t. Inpatient Psychiatric and Behavioral Health Patients. The evaluation for psychiatric patients shall include the following (Joint Commission standard):

(1) History of emotional, behavioral, and substance abuse problems, their co-occurrence, and treatment

(2) Current emotional and behavioral functioning

(3) Maladaptive or problem behaviors

(4) Psychosocial assessment

(5) Legal assessment, when appropriate

u. DNR/Advance Directives. Documentation of the physician's order regarding Advance Directives shall be placed in the chart and reviewed/reissued each Monday. A progress note must document implementation of Advance Directives and include the following (Medical Staff Bylaws):

(1) Patient's name (or authorized surrogate's name)

(2) Patient's diagnosis and prognosis

(3) Assessment of the patient's decision-making capacity and, if capacity is lacking, the likelihood of it being recovered in a reasonable period of time

(4) Treatment options presented for patient or surrogate decision-maker consideration

(5) Patient's or surrogate decision-maker's decision(s) concerning life sustaining treatment

(6) Life-sustaining treatment to be withheld or withdrawn

v. Authentication. Authors of documents are liable for the content of copied items within the document they authenticate. Physicians and other caregivers shall electronically or physically sign all their notes and entries in the paper and electronic medical record. Physicians and other caregivers shall monitor their computerized prompts for signature, currently known as "View-Alerts." Documents requiring signature specifically include, but are not limited to, history, physical exam, admitting assessment and plan (these first four are often combined in one document), patient orders, consultations, reports and notes on operative or invasive procedures, discharge summaries, and informed consent documents (Joint Commission standards).

3. PROCEDURES:

a. Major medical record deficiencies include failure to:

(1) Dictate or enter a discharge summary

(2) Dictate an operative note, or enter a brief chart note when dictation is delayed

b. Minor medical record deficiencies include failure to:

(1) Write an admission assessment (including history, physical examination, assessment, and therapeutic plan)

(2) Write an attending physician admission note

(3) Write a problem list on an outpatient

(4) Properly order and monitor seclusion and restraint

(5) Complete the nursing admission assessment

(6) Complete a Death Note

(7) Authenticate a record entry on a timely basis

c. The Health Information Management Section (HIMS) shall monitor major deficiencies and prepare a monthly report for the Medical Record Committee. The responsible clinician or other designated responsible party in the medical chain of command must remedy major medical record deficiencies.

d. CPRS/VistA tracks authentication deficiencies for the electronic records and HIMS shall track paper record deficiencies. CPRS users are required to respond to the View-Alerts, which notify them of documents needing authentication. The Information Resource Management (IRM) Office's Clinical Coordinators shall assist clinicians to monitor and remedy authentication deficiencies. The IRM office may refer cases to HIMS and the Medical Record Committee as needed for further action.

e. Enforcement and Sanctions for Violations.

(1) Physicians or other clinical staff with major medical record deficiencies shall either promptly correct them, or other clinicians in the chain of medical command authority will become responsible for correcting the deficiency.

(2) Clinicians who are repeatedly noted in HIMS/Medical Record Committee monthly deficiency reports shall be identified in a memorandum written by the Chairman of the Medical Record Committee to the responsible Care Team and the Chief of Staff. The memorandum shall identify the violations. In the case of residents, a copy will be sent to the training director(s). The memorandum will ask that repeated deficiencies be noted in the clinician's evaluation. The Chief of Staff and Associate Chief of Staff for Academic Affiliations have the option of refusing to accept the clinical services of a repeatedly delinquent resident or attending staff member.

4. REFERENCES:

Medical Staff Bylaws
Joint Commission Standards
Center Policy Memorandum 11.10, "Supervision and Work Hours Limitation for Postgraduate Medical, Surgical, Dental, Optometry and Podiatry Residents"
Center Policy Memorandum 136.01, "Medical Records"
Center Policy Memorandum 11.24, "Patient Consent and Notification of Relatives"
Center Policy Memorandum 11.07, "Patient and Family Health Education"
Center Policy Memorandum 118.02, "Seclusion and Restraint"
VHA Directive 2004-018, "Recording Observation and/or Short Stay Patients"
VHA Directive 2009-019. "Ordering and Reporting Test Results"
Center Policy Memorandum 11.57. Proper Use of Copying and Pasting in the Computerized Patient Record System (CPRS)

5. RESCISSION: Center Policy Memorandum 11.05, "Medical Record Completion Policy," dated June 29, 2015.

6. RECERTIFICATION DATE: On or before the last day of August 2021.

7. FOLLOW-UP RESPONSIBILITY: Chief of Staff (11)

Shella Stovall, MNA, RN
Director
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