


Name of Policy:	<u>Ambulatory Medical Record</u>	 <p>Effective Date: 6/7/2011 Initial Effective Date: October 12, 1982</p>
Policy Number:	3364-101-02-01	
Department:	Ambulatory Services	
Approving Officer:	Sr. Vice President and Executive Director, UTMC	
Responsible Agent:	Interim Director, Primary Care Clinics	
Scope:	Ambulatory Services	
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy		<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy

(A) Policy Statement

An institutional ambulatory medical record must be maintained on all patients seen in Ambulatory Services.

(B) Purpose of Policy

To provide documentation for continuity of patient care in accordance with regulatory agency requirements and the University of Toledo Medical Center (UTMC) policies. In addition, to provide for the assembly of all components of a patient's record, regardless of their location in the hospital, when the patient is admitted or is seen for ambulatory or emergency care **in an accurate and timely manner.**

(C) Procedure


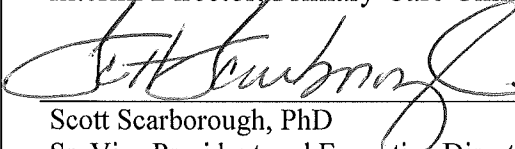
1. All UTMC physicians and patient care staff who are involved in the care of the patient must document in the ambulatory medical record at the time of the encounter.
2. All outpatient medical records will be accessible for patient care and stored in a secured location approved by the Director of Health Information Management. **For all dates of services after March 1, 2008, office documentation will be viewable in Horizon Patient Folder.**
3. **For Charts not available for viewing in Horizon Patient Folder, :**
 - A. Health Information Management will utilize Misys schedule
 - B. Add-on patients' medical records will be requested electronically by **fax or telephone.**
 - C. The Health Information Management Department may request that clinics on Misys fax a back up copy during periods of computer unavailability.
4. **Components of Ambulatory Medical Records**
The ambulatory record shall include the following:
 - A. Adequate patient identification to include demographic and insurance information **with the use of two patient identifiers**
 - B. Pertinent history and physical findings along with the medical and nursing assessments and screens performed.
 - C. Laboratory test, radiology reports, rehabilitation and evaluations and therapies, outpatient surgeries, and consultation findings shall be filed according to an indexed system.

- D. Copies of discharge summaries, operative notes, and pathology reports from each UTMC admission are included. These records can be obtained by providing the patient's name and six digit medical record number to the Health Information Management Department.
 - E. The content and format of the outpatient chart must be maintained in a consistent manner for accessibility of patient information.
 - F. Documentation generated by offices must be filed in the outpatient chart by office staff at the time of the encounter. If the chart is not available, the documentation should be sent to the Health Information Management Department for attachment.
 - G. All original documents will be made part of the outpatient chart. For **centralized** locations, separate records will be maintained in each service's office and should be considered the patient's record of care. For **centralized** offices, the service location is designated on the hospital information system with the ultimate goal of loading the existence of these separate records into the Health Information Management chart tracking system. The attached listing specifies those offices who have decentralized records.
 - H. Offices maintaining decentralized records will be responsible for maintaining these records in a reasonable order, utilizing standard UTMC folders. For purposes of patient care, information exchange between offices during normal business hours will be handled through faxing or sending of copies of pertinent information to the requesting office/physician prior to the patient's appointment.
 - I. For after hour retrieval of records from offices located on site, the Health Information Management Department will retrieve records from these areas if requested. For after hour retrieval of records from offsite offices, Health Information Management Department will be contacted. Since these records will be the complete record of care rendered for these services, they will be utilized for outside requests for release of information and for internal and external audits. Those offices **not serviced by the vendor service contracted by the hospital**, will handle the general release of information requests for continuity of care purposes following the institutional release of information policies. The offices will seek guidance from the Health Information Management Department for any **attorney, hospital third party payor/audit requests or for any subpoenas they might receive.**
 - J. **Duplicates of original records will not be kept.**
5. Components of Patient Visits:
- A. Each entry will begin with the date and name of the office or specialty areas where the patient is seen. Please use hospital provided registration stickers on all correspondence when possible.
 - B. Documentation shall relate only accurate, descriptive, and factual information. When possible, the patient's own words may be used to describe their symptoms or reason for visit.
 - C. Documentation shall occur with each patient visit and shall reflect the following:
 - 1. **Name of office**
 - 2. Patient's name, sex, address, medical record number and date of birth, **with minimum use of two patient identifiers**
 - 3. **General Consent to Treatment updated yearly**
 - 4. **Notice of Privacy Practices updated yearly**
 - 5. Chief complaint or reason for visit
 - 6. Vital signs, body measurements, hearing and vision screening, and other information at the time of visit must be recorded by patient care personnel - as directed by the physician and any JCAHO required documentation including, but not limited to: Nutrition Assessment, Pain Assessment, Fall Risk Assessment, and Communication methods. This is dependent on each individual office.
 - 7. The physician will legibly record the following minimum data at the time of visit:
 - a. Date
 - b. Service
 - c. Patient Diagnosis
 - d. Condition of Patient
 - e. Recommendations/plan of management including:

- 1) Medications-name, dosage, **method and site of administration, manufacturer lot number and expiration date (if applicable), name of person administering the medication**, and schedule
- 2) Tests and consultations
- 3) **Diagnostic and Therapeutic Orders**
- 4) Other therapies
- 5) Patient disposition and instructions
- 6) **Patient understanding of education provided.** Patient care staff will record patient disposition and any patient instructions given to patient and/or family for follow-up care.

- D. All entries are legible and completed in black ink
- E. Legible signature, with title, date and time of signature
- F. Problem List/Medication Profile after the third visit, including allergies, medications, invasive procedures and diagnoses. Maintenance of the Ambulatory Problem List will follow policy number 3364-101-02-06.

6. **When a documentation error occurs, a single line is to be drawn through the entry and the word: "error" shall be written over the line followed by recorders name, title, date and time as outlined in policy 3364-100-53-18.**
7. Confidentiality of Patient Information: All information in the outpatient chart is strictly confidential. Access to this information is restricted to health care personnel directly involved in patient care and personnel involved in the storage and retrieval of this data.
8. **All components of the ambulatory medical record documentation must be complete and present within seven (7) business days.**

<p>Approved by:</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;">  <hr/> Olivia Dacre, MBA Interim Director, Primary Care Clinics </div> <div style="width: 45%; text-align: center;"> <p>6-7-11 Date</p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%;">  <hr/> Scott Scarborough, PhD Sr. Vice President and Executive Director, UTMC </div> <div style="width: 45%; text-align: center;"> <p>6/20/11 Date</p> </div> </div> <p style="margin-top: 20px;"><i>Review/Revision Completed By:</i> Ambulatory Services Health Information Management</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: left; padding: 5px;">Review/Revision Date:</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px 5px;">6/12/84</td> <td style="padding: 2px 5px;">10/96</td> <td style="padding: 2px 5px;">10/10</td> </tr> <tr> <td style="padding: 2px 5px;">8/20/85</td> <td style="padding: 2px 5px;">3/98</td> <td style="padding: 2px 5px;">6/7/2011</td> </tr> <tr> <td style="padding: 2px 5px;">5/20/86</td> <td style="padding: 2px 5px;">11/98</td> <td></td> </tr> <tr> <td style="padding: 2px 5px;">4/21/87</td> <td style="padding: 2px 5px;">3/99</td> <td></td> </tr> <tr> <td style="padding: 2px 5px;">11/03/88</td> <td style="padding: 2px 5px;">3/01</td> <td></td> </tr> <tr> <td style="padding: 2px 5px;">5/15/90</td> <td style="padding: 2px 5px;">3/02</td> <td></td> </tr> <tr> <td style="padding: 2px 5px;">9/20/90</td> <td style="padding: 2px 5px;">8/02</td> <td></td> </tr> <tr> <td style="padding: 2px 5px;">7/92</td> <td style="padding: 2px 5px;">4/05</td> <td></td> </tr> <tr> <td style="padding: 2px 5px;">10/93</td> <td style="padding: 2px 5px;">11/07</td> <td></td> </tr> </tbody> </table> <p style="margin-top: 20px;">Next Review Date: 6/1/2014</p>	Review/Revision Date:			6/12/84	10/96	10/10	8/20/85	3/98	6/7/2011	5/20/86	11/98		4/21/87	3/99		11/03/88	3/01		5/15/90	3/02		9/20/90	8/02		7/92	4/05		10/93	11/07	
Review/Revision Date:																															
6/12/84	10/96	10/10																													
8/20/85	3/98	6/7/2011																													
5/20/86	11/98																														
4/21/87	3/99																														
11/03/88	3/01																														
5/15/90	3/02																														
9/20/90	8/02																														
7/92	4/05																														
10/93	11/07																														
Policies Superseded by This Policy: 2-01 and 2-02																															

University of Toledo Medical Center

AMBULATORY SERVICES LISTING OF DECENTRALIZED RECORDS

For some areas records will be decentralized and will be considered the patient's record of care. These areas are:

- Geriatric Center
- South Toledo Internists
- Family Practice
- Pediatrics
- Medicine Clinics
- Psychiatry
- Cancer Institute
- Hematology/Oncology
- Urology
- Neurosurgery
- Cardiac Rehab
- Breast Care Center