


Name of Policy: <u>Medical Records, H&Ps, Inpatient, Observation and Outpatient Procedures</u>		 Effective Date: 8/1/2017 Initial Effective date: 05/10/00
Policy Number: 3364-87-02		
Approving Officer: Chief of Staff		
Responsible Agent: Chief Medical Officer		
Scope: All University of Toledo Campuses		
<input type="checkbox"/>	New policy proposal	<input type="checkbox"/> Minor/technical revision of existing policy
<input checked="" type="checkbox"/>	Major revision of existing policy	<input type="checkbox"/> Reaffirmation of existing policy

(A) Policy Statement

It is the policy of the University of Toledo Medical Center (“UTMC”) and its Medical Staff that an adequate medical record, incorporating all significant clinical information pertaining to that patient, will be maintained for every person admitted as an inpatient or undergoing an outpatient procedure.

(B) Purpose of Policy

To clarify what must be included in that medical record and how it will be maintained.

(C) Procedure

1. Every medical record entry will be timed, dated, and its author identified, as defined in hospital policy #3364-100-53-18. All written entries in the medical record must be in black ink.
2. Abbreviations or symbols are acceptable only if they appear on a standard list approved by the Medical Staff Executive Committee.
3. The final patient diagnosis will be recorded without the use of symbols or abbreviations and will be recorded at the time of discharge of the patient.
4. Each and every report in the medical record must contain patient’s name, and medical record number, time and date of entry or date report completed, and signature and title of person responsible for the entry or report.
5. All medical student entries and reports in a medical record must be co-signed by the attending physician or designee.
6. Only forms accepted and approved by the Health Information Management Committee may be used in a patient’s medical record.
7. All outside records obtained should be included in inpatient records identifying the source.
8. There must be a discharge order for every patient leaving UTMC except in the case where the patient leaves UTMC against medical advice or expires.
9. When a patient expires, a summation statement is entered into the medical record as a final progress note.

10. The medical record for every patient admitted to UTMC or undergoing an invasive or high risk procedure or sedation, other than minimal sedation (referred to as "Procedure") must include or comply with all of the following:

- a) Identification data and informed consent forms, except in an emergency when unobtainable.
- b) All histories and physicals ("H&P") must be legible. In the event that a patient is in need of urgent Procedure, a handwritten or electronically entered history and physical may be substituted for the dictated report. The history should be a record of the information provided by the patient, or by his/her agent. The patient's chief complaint should be stated in a concise manner. The physician admitting the patient will be responsible for completion of the history. The history must be completed within 24 hours after admission and prior to Procedure.

The history and physical will contain at a minimum:

- Chief complaint
- History of present illness (details of condition including, when appropriate, assessment of patient's emotional and behavioral status)
- Relevant past medical or surgical history, current medications and allergies
- Clinically relevant family and social history appropriate to patient's age (may indicate N/R for not clinically relevant)
- Review of systems
- Pertinent physical examination, including vital signs
- Diagnostic results, if available and appropriate
- Diagnosis/problem list with initial plan of care
- Date, time and signature.

2) The attending physician or designee (Resident, NP or PA) may complete and document the H&P. If the H&P is completed by a designee of the attending physician who is not a licensed independent practitioner (Residents and midlevel providers like Physician Assistants or Advance Practice Nurses where completion of an H&P is not within such person's scope of practice), the attending physician must validate and review the content with a signature within twenty-four hours after admission or registration, and prior to the performance of any invasive procedure or sedation, other than minimal sedation.

- c) If a complete history has been recorded, and a physical examination performed within 30 days prior to the patient's admission to the Medical Center or the date of the Procedure, a reasonably durable, legible and signed copy of these reports may be used in the patient's medical record, provided these reports were recorded by a member of UTMC's medical staff. For hospitalized patients, daily progress notes will qualify as an updated examination. The physician or other individual qualified to perform the H&P must write and sign an update note addressing the patient's current status, within 24 hours of the admission and prior to a Procedure. A patient is not to be taken to a procedure room without these requirements being met. The physician admitting the patient and conducting the physical examination will be responsible for completion of the reports. All dental patients' records will contain a physical examination report by the dentist and a physical examination report by the attending physician. All podiatric patients' records will contain a physical examination report by the podiatrist and a physical examination report by the attending physician. The attending physician will be responsible for co-signing the history and physical examination on all dental and podiatry patients.
- d) Diagnostic and therapeutic orders include orders written or electronically entered by authorized house staff members and by individuals granted clinical privileges. All telephone or verbal diagnostic and therapeutic orders must be authenticated by a physician within thirty (30) days

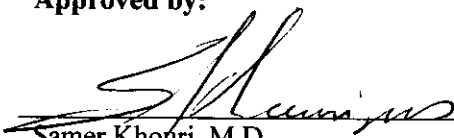
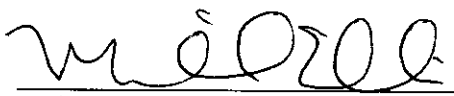
after the order is given. Telephone or verbal orders signed on the physician paper order sheet must be dated and timed and include the name of the ordering physician and the name of the person writing or taking the order. Telephone or verbal orders may be taken by those designated in Policy #3364-100-53-16. Routine postoperative-orders guiding patient care following a procedure may be entered (signed, dated and timed) at any time during the specific episode of care provided that appropriate subsequent modifications and revisions are made and dictated by clinical circumstances coincident with the evolving patient condition.

- e) Observations reports should include progress notes by authorized house staff members and individuals who have been granted clinical privileges, consultation reports, nurses' notes, and entries by allied health personnel.
- f) Progress notes by the Medical Staff must give a pertinent chronological report of the patient's course of care and treatment and be sufficient to describe changes in the patient's condition and the results of treatments. There will be, at least, an admission and discharge progress note. All progress notes must be timed, dated and authenticated by the person making such entries.
- g) Written consultation reports must be legible. A consultation will contain an opinion by the consultant based on an examination of the patient and his/her record. All consultation reports must be timed, dated and signed by the consultant. The consulting physician must complete a request for consultation and indicate the reason for the consultation.
- h) Reports of actions and findings should include such items as reports of pathology and clinical laboratory examinations, radiology examinations, medical and surgical treatment, and any other diagnostic or therapeutic procedures. All diagnostic and therapeutic procedures must be recorded and authenticated in the medical record.
- i) Except in an emergency, no surgery will be performed unless informed consent is obtained. Where surgery or other procedures ordinarily requiring informed consent are performed in an emergency without consent, the practitioner will record in the medical record attempts that were made, that the attempts were unsuccessful, and the reasons therefore.
- j) There must be a pre-anesthesia evaluation of the patient with appropriate documentation of pertinent information relative to the choice of anesthesia and surgical and obstetrical procedure anticipated. The evaluation should include the patient's previous drug history, other anesthetic experiences and consideration of potential anesthetic problems. There must be a recording of all events taking place during the induction, maintenance, and emergence from anesthesia including the dosage and time of administration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood fractions. Post-anesthetic evaluations must note and describe the occurrence of anesthesia-related complications when appropriate. All entries must be timed, dated and authenticated by the person making the entries.
- k) A post-operative Procedure report in the form of a progress note must be completed immediately following the conclusion of a Procedure and before the patient is transferred to the next level of care. The progress note may be signed by the attending surgeon or resident surgeon. A detailed (dictated) Procedure report must be in the medical record within twenty four (24) hours of the conclusion of the Procedure and signed by the attending surgeon promptly, but no later than thirty (30) days of completion of Procedure.
 - 1) The immediate post-op Procedure progress note must include at a minimum:
 - a. pre-operative and post-Operative diagnosis;
 - b. name of the specific procedure(s) performed, may include relevant findings;

- c. name of the attending surgeon(s) and resident surgeons and the specific significant surgical tasks that were conducted by the practitioners other than the primary surgeon;
 - d. type of anesthesia administered;
 - e. the estimated blood loss (may include fluids);
 - f. a description of tissues/specimens removed or altered;
 - g. prosthetic devices, grafts, tissues, transplants or devices implanted, if any; and
 - h. Dates and times of the surgery in addition to the physician's signature, date and time.
- 2) The detailed (dictated) post-operative report must contain the same items above plus an appropriately detailed description of the findings and techniques (technical steps taken to complete the procedure).
- 3) The medical record must contain the following post-operative information:
- a. The patient's vital signs and level of consciousness;
 - b. Any medications, including intravenous fluids and any administered blood, blood products and blood components;
 - c. Any unanticipated events or complications, including blood transfusion reactions and management of those events.
- l) Reports of nuclear medicine interpretations, radiological interpretations, laboratory test interpretations, and therapy interpretations must be included in the patient's medical record, and must be dated and authenticated by the individual making the interpretations.
- m) A report must be made on all tissue specimens removed and must be dated and authenticated by the pathologists completing the test.
- n) The results of patients receiving transfusions of blood and any apparent transfusion reaction must be reported and any tests concerning same must become a permanent part of the patient's medical record.
- o) Each necropsy procedure, and the record thereof, will be sufficiently drafted to meet the needs of the Medical Staff. Provisional anatomic diagnosis should be recorded in the patient's medical record within 72 hours, where feasible; the complete protocol should be made part of this record within three (3) months.
- p) The written discharge summary must be legible. These should include the provisional, primary, secondary and final diagnoses, clinical resume, and necropsy reports. The provisional diagnosis should reflect the admitting clinical diagnosis. All relevant discharge diagnoses will be recorded, using the terminology of standard nomenclature, and without the use of symbols and abbreviations. The clinical resume, or discharge summary, will briefly outline the significant findings and events of the patient's hospitalization, condition on discharge and recommendations and arrangements for future care. A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who required less than a 48-hour period of hospitalization. The final progress notes should include any instructions given to the patient and/or family. It is recommended that the discharge summary be completed at the time patient is discharged, but no later than 24 hours post discharge. The physician discharging the patient will be responsible for completion of the discharge summary. All records must be completed within **20** days of discharge.

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11. In cases where a resident is unable to complete a medical record, the attending physician will have final responsibility for completion. In cases where the attending physician is unable to complete a medical record, the record will be referred to the Health Information Management Committee for disposition.

<p>Approved by:</p> <p> Samer Khotri, M.D. Chief of Staff</p> <p><u>8/2/17</u> Date</p> <p> Michael Ellis, M.D. Chief Medical Officer</p> <p><i>Review/Revision Completed By: Medical Staff Executive Committee</i></p>	<p>Review/Revision Date:</p> <p>11/08/00 8/1/2017 04/10/02 09/11/02 11/13/02 02/12/03 05/12/04 04/29/05 08/09/06 09/12/07 09/24/08 11/25/09 08/31/12 10/24/12 11/30/12 11/26/14</p> <p>Next Review Date: 8/1/2020</p>
<p>Policies Superseded by This Policy: MS-002</p>	