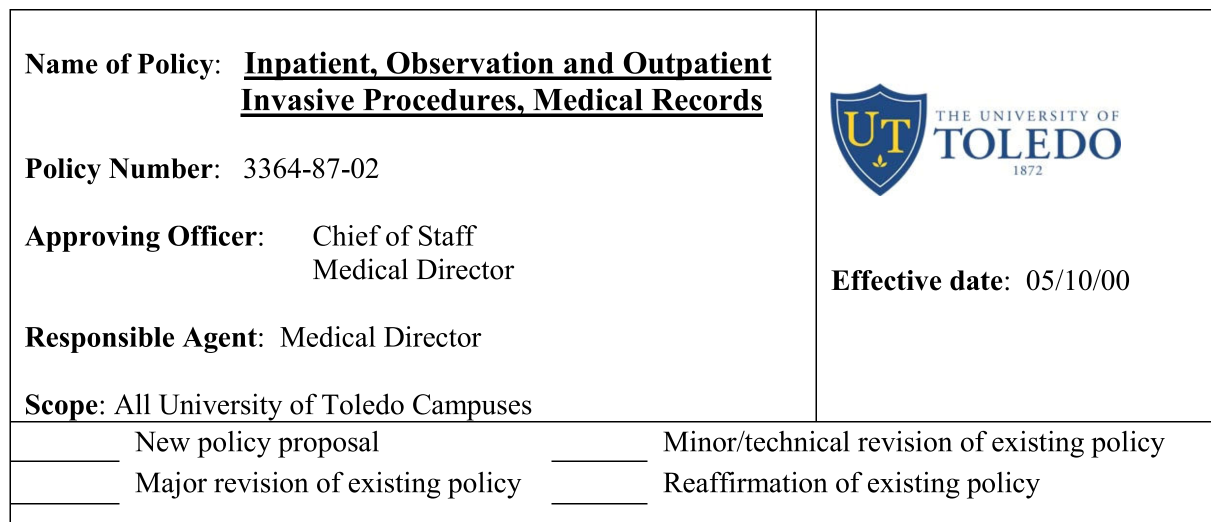

Name of Policy: **<u>Inpatient, Observation and Outpatient Invasive Procedures, Medical Records</u>**

Policy Number: 3364-87-02

Approving Officer: Chief of Staff
Medical Director

Responsible Agent: Medical Director

Scope: All University of Toledo Campuses

Effective date: 05/10/00

________	New policy proposal	________	Minor/technical revision of existing policy
________	Major revision of existing policy	________	Reaffirmation of existing policy

(A) Policy statement

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

(B) Purpose of policy

To identify guidelines as to what may and/or must be included in that medical record and how it will be maintained.

(C) Procedure

(1) Every medical record entry shall be dated and its author identified, as defined in hospital policy #7-53-18. All 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 Executive Committee.

(3) The final diagnosis shall be recorded without the use of symbols or abbreviations and shall be recorded at the time of discharge of the patient.

(4) Each and every report in the medical record shall contain patient's name, and medical record number, 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 shall be co-signed by the attending physician or his designee.

(6) Only forms accepted and approved by the Health Information Management Committee shall be used in a patient's medical record.

(7) All outside records obtained should be included in inpatient records.

(8) There must be a discharge order for every patient leaving the Medical Center except in the cases where the patient leaves the Medical Center 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) An adequate medical record for every patient admitted to the Medical Center or undergoing an invasive procedure shall include all of the following:

(a) Identification data and consent forms, except when unobtainable.

(b) All histories and physicals must be written on either the general pre-printed History and Physical form, the individual service's pre-printed History and Physical form, or dictated.

(c) The outpatient H&P form is to be used for outpatient surgery and observation patients. Inpatient H&P will be used for all inpatients.

(i) History of the patient – this record shall incorporate the chief complaint, details of present illness, review of systems, past history, social history, and family history, except when unobtainable. 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 shall be responsible for completion of the history. All dental patient's records shall contain a history by the attending physician. The history must be completed within 24 hours after admission and prior to an invasive procedure.

(ii) Physical examination of the patient – this record shall include all pertinent findings resulting from an assessment of the systems of the body. 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 invasive 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 the 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 an invasive 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 shall be responsible

for completion of the reports. All dental patients' records shall contain a physical examination report by the dentist and a physical examination report by the attending physician. All podiatric patients' records shall contain a physical examination report by the podiatrist and a physical examination report by the attending physician. The attending physician shall be responsible for co-signing the history and physical examination on all dental and podiatry patients.

(d) Diagnostic and therapeutic orders – these orders shall include those written by authorized house staff members and by individuals granted clinical privileges. All verbal orders must be authenticated by a physician within 48 hours after the order is given. Verbal orders signed on the physician order sheet must be dated and include the name of the ordering physician and the name of the person writing or taking the order. Verbal orders may be taken by those designated in Policy #7-53-16.

Unless a time limitation is specifically indicated by the physician, all orders for antibiotics are to be effective for eight days only. The pharmacy will send notices after seven days of therapy that the drug order will be in effect for only one more day. The physician and nurse on the ward should review the order and, if further therapy is deemed necessary, the drug order must be rewritten by the physician.

(e) Observations – these 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.

Progress notes by the Medical Staff should give a pertinent chronological report of the patient's course of care and treatment and should be sufficient to describe changes in the patient's condition and the results of treatments. There shall be, at least, an admission and discharge progress note. All progress notes shall be dated and authenticated by the person making such entries.

Consultation reports shall contain a written opinion by the consultant based on an examination of the patient and his/her record. All consultation reports shall be dated and signed by the consultant. The consulting physician shall complete a request for consultation and indicate the reason for the consultation. This report shall be dated and signed by the consulting physician.

(f) Reports of actions and findings – these reports 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 shall be recorded and authenticated in the medical record.

Except in an emergency, no surgery shall 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 shall record in the medical record attempts that were made, that the attempts were unsuccessful, and the reasons therefore.

There shall 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 shall 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 shall note and describe the occurrence of anesthesia-related complications when appropriate. All entries shall be dated and authenticated by the person making the entries.

Procedure/operative dictated report or progress note shall be present immediately following the completion of procedure(s). If a progress note is entered immediately following the procedure, the dictated or written operative/procedure report must be present within 24 hours of completion of the procedure(s). The operative note/procedure report must include the name of the surgeon and assistants, procedure(s) performed, and description of each procedure, findings, estimated blood loss, specimens removed, disposition of each specimen, and postoperative diagnosis. The attending surgeon/procedure physician should review and sign the dictated operative report as soon as possible after the procedure.

Reports of nuclear medicine interpretations, radiological interpretations, laboratory test interpretations, and therapy interpretations shall be included in the patient's medical record, and shall be dated and authenticated by the individual making the interpretations.

A report shall be made on all tissue specimens removed and shall be dated and authenticated by the pathologists completing the test.

The results of patients receiving transfusions of blood and any apparent transfusion reaction shall be reported and any tests concerning same shall become a permanent part of the patient's medical record.

Each necropsy procedure, and the record thereof, shall 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.

(g) Conclusions – These should include the provisional diagnosis, primary, secondary and final diagnoses, clinical resume, and necropsy reports. The provisional diagnosis should reflect the admitting clinical diagnosis. All relevant discharge diagnoses shall be recorded, using the terminology of standard nomenclature, and without the use of symbols and abbreviations. The clinical resume, or discharge summary, shall 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 shall be responsible for completion of the discharge summary. All records must be completed within 30 days of discharge.

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

<table>
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<td>Approved by:

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Christopher K. Lynn, M.D.
Chief of Staff

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Ronald McGinnis, M.D.
Medical Director

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Date

Review/Revision Completed by:
Health Information Management Committee
Medical Executive Committee</td>
<td>Policies Superseded by This Policy:
• MS-002 Inpatient, Observation and Outpatient Invasive Procedures, Medical Records

Review/Revision Date: 11/08/00
04/10/02
09/11/02
11/13/02
02/12/03
05/12/04
04/29/05
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Next review date: 09/12/10</td>
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