


Name of Policy:	<u>Legal Ambulatory Medical Record</u>	 THE UNIVERSITY OF TOLEDO MEDICAL CENTER
Policy Number:	3364-101-02-01	
Department:	Ambulatory Services	
Approving Officer:	CAO, OP Clinic Operations	
Responsible Agent:	COO - UTMC	
Scope:	Ambulatory Services	
		Effective Date: 7/1/2023 Initial Effective Date: October 12, 1982
<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 Electronic Medical Record (EMR) must be maintained on all patients seen in Ambulatory Services, the Department of Dentistry will maintain a paper –based medical record.

(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) and University of Toledo Physicians(UTP) 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/UTP providers 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
3. 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 reports.
 - d. Copies of discharge summaries, operative notes, and pathology reports from each UTMC admission are included in the Medical Records tab of the Clinical Portal.
 - e. All original documents will be scanned/filed into the outpatient chart.
 - f. Once the outside documents have been scanned into the electronic medical record and presence verified, the documents can then be shredded in the appropriate receptacle. Documents that are part of UTMC/UTP will be scanned and kept for a period of 90 days and then shredded. Please use hospital provided registration stickers on all correspondence when possible.
4. Components of Patient Visits:
 - a. 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.
 - b. Documentation into the medical record shall occur with each patient visit and shall reflect the following:
 - i. Name of office
 - ii. Patient’s name, sex, address, medical record number and date of birth, with minimum use of two patient identifiers

- iii. General Consent to Treatment updated yearly
 - iv. Notice of Privacy Practices updated yearly
 - v. Chief complaint/history of present illness to be completed by the provider for visit.
 - vi. 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 provider and any Joint Commission required documentation including, but not limited to: Pain, Nutrition Screen, Fall Risk Screen, Suicide Screen, Abuse Screen and Communication methods. This is dependent on each individual office.
 - vii. The provider will record the following minimum data at the time of visit:
 - a. Patient Diagnosis
 - b. Condition of Patient
 - c. 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/referrals
 - 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.
5. 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.
6. All components of the ambulatory medical record documentation must be complete and present within 7 days of patient encounter. In cases where patients will be admitted to hospitals from a clinic, the clinic encounter note to support admission must be completed and closed in the electronic medical record..

Approved by:	Review/Revision Date:
/s/	6/12/84 10/96 10/10
_____	8/20/85 3/98 6/7/2011
Marci Cancic-Frey PT DPT MBA	5/20/86 11/98 8/2014
Senior Administrative Director-Clinic Operations	4/21/87 3/99 7/1/2017
/s/	11/03/88 3/01 5/19/2020
_____	5/15/90 3/02 6/30/2023
Christine Stesney-Ridenour, FACHE – UPMC	9/20/90 8/02
Chief Operating Officer	7/92 4/05
	10/93 11/07
<i>Review/Revision Completed By:</i> <i>Ambulatory Services</i>	Next Review Date: 07/1/2026
Policies Superseded by This Policy: 2-01 and 2-02	