Name of Policy:	Documentation standards
Policy Number	3364-87-42
Approving Officer:	Chief of Staff
Responsible Agent:	Chief Medical Officer/Health Information Management (HIM)
Scope:	All University of Toledo Campuses

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: 09/01/2023

Initial Effective date: 3/5/2019

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

(A) Policy Statement

The University of Toledo Medical Center (UTMC), medical staff, residents, advanced practice providers (APPs), medical students, and licensed/certified staff that document within patients' medical record will provide accurate and complete documentation in compliance with Federal and State laws, rules and regulations and other accrediting body regulations and standards.

(B) Purpose of Policy

Documentation integrity involves the accuracy of the complete health record. The procedure below provides guidance to UTMC workforce members. To ensure compliance with Federal and State laws, rules and regulations and accrediting standards in regards to documentation requirements within the medical record for ambulatory, outpatient procedures, inpatient and observation.

(C) Procedure

A medical record will be maintained in electronic or paper format for every patient who receives services at UTMC and affiliated clinics.

1. Signature Requirements

Every medical record entry must be timed, dated, and its author identified with either electronic or ink signature as defined in hospital policy #3364-100-53-18. All written entries in the medical record must be in black ink.

(a) **Residents**: The attending physician is responsible for supervising the resident's health care delivery. All resident notes must be countersigned by the attending physician using an approved attestation unless the resident is practicing under the primary care exception as defined by Center for Medicare and Medicaid Services (CMS).

(b) **Advanced Practice Providers** (Physician Assistants, Certified Nurse Practitioners): APPs do not require counter signature of a physician to perform services within their scope of practice and pursuant to their standard care arrangement. Standard Care Arrangement will be maintained with their employer and UT Central Verification office.

(c) **Medical Students**: Medical students may document the History of Present Illness, Physical Exam and Medical Decision Making/Plan for outpatient and inpatient encounters excluding Critical care services. The physician must perform or re-perform the History of Present Illness, Physical Exam and Medical Decision. However, the physician does not have to re-document the encounter but must sign, date and time the encounter with an attestation that the physician performed or re-performed the encounter and made necessary edits to the documentation.

All Medical Students may document the Review of the System and the Past, Family and Social History. The physician must review and comment that the physician has reviewed with the patient. The physician must make any necessary edits.

(d) **Pharmacists**: Pharmacists do not require counter signature of a physician to perform services within their scope of practice and pursuant to their pharmacy consult agreement. Pharmacy consult agreements will be maintained with their employer and the College of Pharmacy.

(e) **Registered Dietitian:** Registered dietitians are permitted to order patient diets independently, pursuant to their scope of practice and as authorized by the UTMC Medical Staff.

(f) **Scribes**: Every medical record entry written by a qualified scribe must be authenticated (signed) by the appropriate provider to adequately document the care provided or ordered. Scribes must be qualified as denoted by the Joint Commission (JC).

2. Documentation – Ambulatory

For all patients seen in Ambulatory Services, documentation will be recorded in an electronic medical record (EMR) and will be accessible for patient care.

All providers and patient care staff must document in the ambulatory EMR at the time of the encounter and all components of the EMR documentation must be complete and present within 3 calendar days of patient encounter. In cases where patients will be admitted to a hospital from a clinic, the clinic encounter note to support admission must be completed and closed in the EMR as soon as possible.

(a) Encounter documentation

i. Documentation must be accurate, descriptive, and contain only factual information. When possible, the patient's own words may be used to describe their symptoms or reason for the visit.

ii. Each patient visit must be documented in the EMR and must reflect the following:

1. Name of the office where the patient visit occurred;

2. Patient's name, sex, address, medical record number and date of birth, with a minimum of two patient identifiers;

3. General Consent to Treatment updated annually;

4. Notice of Privacy Practices at initial visit and when updated and/or changed;

5. The chief complaint/history of present illness must be documented for each visit;

6. Providers and/or patient care staff must record vital signs, body measurements, hearing and vision screening, and other information at the time of visit as directed by the provider and any Joint Commission (TJC) required documentation. This includes, but not limited to: pain, nutrition screen, fall risk screen, suicide screen, abuse screen and communication methods. This is dependent on each individual office; and

7. The provider will record at a minimum the following data at the time of visit:

a. Patient diagnosis

b. Present condition and symptoms of the patient
c. Recommendations/plan of management including:
   i. Medications-name, dosage, method and site of administration, manufacturer lot number and expiration date (if applicable), name of person administering the medication, and schedule;

   ii. Tests and consultations/referrals;

   iii. Diagnostic and therapeutic orders;

   iv. Other therapies;

   v. Patient disposition and instructions; and

   vi. 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.

(b) Components of the ambulatory record shall include the following:

iii. Adequate patient identification to include demographic and insurance information with the use of two patient identifiers.

iv. Pertinent history and physical findings along with the medical and nursing assessments and screens performed.

v. Laboratory test, radiology reports, rehabilitation and evaluations and therapies, outpatient surgeries, and consultation reports.

vi.

vii. All documents must be scanned/filed into the outpatient chart and include hospital registration stickers when possible and appropriate.

(c) Confidentiality of Patient Information: All information in the ambulatory record is strictly confidential. Providers and patient care staff may only access patient health information in accordance with UTMC Health Insurance Portability and Accountability policies: 3364-90-02 Minimum Necessary Guidelines for Use/Disclosure of Protected Health Information and 3364-90-07 Medical Record Availability and Access.

3. Documentation – Inpatient

(a) Every report or entry into the medical record must legible and contain the patient's name, medical record number, date the report is completed or the time and date of entry, and signature and title of person responsible for the report or entry. The entire medical record must be completed within 30 days of discharge.

(b) Admissions, Generally (Admit to Inpatient Status)

i. Physicians with privileges may admit patients to UTMC.

ii. Residents may admit a patient to UTMC, however, a physician with privileges must certify the admission order. Certification involves authenticating the admission order, prior to patient's discharge from the hospital.

iii. APPs with admitting privileges may admit patients to UTMC; however, the APP's supervising or collaborating physician must (1) be notified of the planned admission

prior to admitting a patient and (2) certify the admission order.[1] Certification involves authenticating the admission order, prior to patient's discharge from the hospital.

(c) Observation (Place in Observation- considered outpatient order)

In order to document observation services properly, the medical record must contain dated and timed orders regarding observation services that may include observation and consultation reports and progress notes, including nurse notes, by authorized medical professionals or privileged providers. This is in addition to any ED or outpatient clinic encounter documentation.

(d) History and Physicals (H&Ps) – Inpatient.

i. General.

1. Physicians and APPs are privileged to independently complete H&Ps.

2. Residents may complete the admission H&P but require a co-signature of the attending within 24 hours after admission or registration prior to the performance of any invasive procedure or sedation, other than moderate sedation.

3. The admitting provider is ultimately responsible for completion of the H&P.

ii. Timing.

1. An H&P must be completed within 24 hours of admission,

2. If a complete H&P has been recorded within thirty (30) days prior to the patient's admission, a durable legible copy of the H&P done by a member of the UTMC Medical Staff may be used in the medical record for the current admission.

3. In the event the patient is in need of an urgent procedure, the H &P should be completed as soon as possible after the completion of the procedure.

4. An H&P that is not written on the day of a procedure requiring anesthesia must be updated on the day of, and prior to the procedure, by documenting no significant changes or listing changes in the patient's condition following the patient's examination.

5. A progress note must be documented daily and is sufficient to use for patients having additional surgeries during their hospital stay.

6. Elective inpatient or outpatient surgery is subject to delay or cancellation until a pertinent H&P or progress note is recorded in the patient's medical record.

iii. Contents. The H&P will contain at a minimum:

1. Chief complaint;

2. History of present illness (details of condition including, when appropriate, assessment of patient's emotional and behavioral status);

3. Clinically relevant family history;

[1] The patient will be under the medical supervision of the supervising or collaborating physician. ORC 3727.06.

4. Review of systems;

5. Pertinent physical examination,

6. Diagnostic results, if available and appropriate;

7. Diagnosis with initial plan of care; and

8. Date, time and signature of provider performing the H&P.

(e) Orders/Reports.

i. Telephone/Verbal/Text/Email/Orders. Communication of medical orders falls into several categories including, but not limited to: written, verbal, and telephone orders.

1. Verbal orders are those orders given by licensed health care professionals with appropriate clinical privileges to licensed individuals authorized to receive, record and execute verbal orders in accordance with relevant laws, rules and regulations.

2. Telephone orders are orders communicated verbally through telephonic devices by licensed health care professionals with appropriate clinical privileges to licensed individuals authorized to receive, record and execute telephonic orders in accordance with relevant laws, rules and regulations.

3. All telephone and verbal orders must be authenticated by a provider as soon as possible but no later than 30 days after discharge.

4. Any telephone or verbal order that is reduced to paper must be dated and timed, include the name of the ordering physician or APP, the name of the person writing or taking the order and the method the order was received (telephone or verbal).

5. Texting orders is not permitted per CMS and TJC regulations/standards.

6. UTMC does not permit using email to transmit orders.

ii. Diagnostic and Therapeutic Orders.

1. Diagnostic and therapeutic orders include written or electronic orders entered by appropriately licensed and certified personnel and signed by providers granted clinical privileges.

iii. Progress notes 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.

1. Progress notes must be done daily with a minimum of an admission note and discharge progress note.

2. All progress notes must be timed, dated and authenticated by the provider making the entry.

(f) Reports of Supporting Services.

1. 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 qualified licensed staff making the interpretations.

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

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

4. 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.

5.

6.

(g) Consultations.

i. Consultation requests/orders must include the reason the consult was requested (3364-87-15).

1. After the consultant examines a patient, the consultant must provide a written report addressing all questions and requests made by the requesting provider and provide recommendations back to the requesting provider.

(h) Discharge Orders/Discharge Summary.

i. Discharge orders and discharge summaries may be completed by a physician, APP or resident. The physician discharging the patient is responsible for completion of the discharge summary. If not completed by the physician, the physician must countersign the discharge summary.

ii. The final patient diagnosis must be recorded using the terminology of standard nomenclature and without the use of symbols or abbreviations and must be recorded at the time the patient is discharged.

iii. Every patient admitted to UTMC must have a discharge order and discharge summary unless the patient leaves against medical advice (AMA), then only a discharge summary is completed.

iv. The discharge summary outlines the significant findings and events of the patient's hospitalization, included in the discharge summary:

1. Reason for hospitalization

2. Provisional (admitting clinical diagnosis), primary, secondary and final diagnoses

3. Significant findings

4. Procedures and treatment provided

5. Patient's discharge condition

6. Patient and family instructions (as appropriate)

7. Deceased patient requires a death note with date and time of death documented as well as a brief summary of the hospital stay and events that lead to the patient's death.

v. The discharge summary should be completed at the time patient is discharged, but no later than 24 hours post discharge. 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 note should include any instructions given to the patient and/or family.

4. Use of Abbreviations

(a) Abbreviations are a standardized and uniform use of codes, symbols and abbreviations that have been approved for use.

(b) UTMC uses standardized diagnosis and procedure codes and requires use of approved symbols and abbreviations across UTMC and affiliated clinics.

(c) The use of abbreviations is prohibited in informed consent forms, patient rights documents, discharge instructions, and other documents provided to patients and families. The following abbreviations should NOT be used for medication in the paper or EMR:

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate. Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

5. Anesthesia

(a) There must be a pre-anesthesia evaluation of the patient with appropriate documentation of pertinent information relative to the choice of anesthesia and surgical procedure anticipated.

The evaluation should include, other anesthetic experiences and consideration of potential anesthetic problems.

(b) 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.

(c) Post-anesthetic evaluations must note and describe the occurrence of anesthesia-related complications, when applicable.

(d) All entries must be timed, dated and authenticated by the provider making the entries.

6. Post-Operative Documentation

(a) The detailed operative note or Brief Op Note must be completed before a patient leaves the Post anesthesia care unit (PACU) after any operation or other high-risk procedure. If a Brief Op Note is completed, then the detailed operative note must be completed within 24 hours. The Brief Op Note may be signed by the attending surgeon or resident surgeon.

i. The Brief Op Note/procedure note must include at a minimum:

1. Pre-operative and post-operative diagnosis;

2. Name of the specific procedure(s) performed, may include relevant findings;

3. Name of the attending surgeon(s) and resident surgeons, if any, and the specific significant surgical tasks that were conducted by the providers other than the primary surgeon;

4. Type of anesthesia administered;

5. Estimated blood loss (may include fluids);

6. Description of tissues/specimens removed or altered;

7. Prosthetic devices, blood transfusions, grafts, tissues, transplants or devices implanted, if any; and

8. Dates and times of the surgery in addition to the physician's signature, date and time.

9. Any unanticipated events or complications

ii. The detailed 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).

7. Health Information Management

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

(b) All outside records received for a patient must be included in the patient's medical record identifying the source.

8. Incomplete Medical Record

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 HIM Committee for disposition. If an APP does not complete the medical record the APP's supervising physician will be notified. Additional requirements regarding delinquent medical records can be found in Policy #3364-87-03.

9. Attestations

Only those attestations approved by CMS or the UTMC Compliance Office may be used by providers in a patient's medical record.

10. Attachments

The following documents are attached to this policy and incorporated herein:

(a) Attachment A: Policy Crosswalk

(b) Attachment B: Personnel Authorized to Make Entries into the Medical Record

Approved by:		**Review/Revision Date:**
		03/01/2020
/s/	09/06/2023	07/24/2023
Puneet Sindhwani, M.D. Chief of Staff	Date	
/s/	09/06/2023	
Michael Ellis, M.D. Chief Medical Officer	Date	
Review/Revision Completed By: *Medical Staff Executive Committee*		
		Next Review Date: 09/01/2026

Policies Superseded by This Policy: 3364-87-02 – Medical Records, H&Ps, Inpatient, Observation and Outpatient Procedures; 3364-100-70-11 – Use of Abbreviations; 3364-110-04-03 – Medical Orders; 3364-100-53-16 – Verbal Orders Including Orders; 3364-100-53-18 – Handwritten Entries in the Medical Record and Electronic Signature in Transcribed Reports.

Attachment A: Policy Crosswalk

Documentation	Resident		APP		Medical Student		Pharmacists		Scribe		Notes
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Physician Signature Required	1(a)			1(b)	1(c)			1(d)	1(e)		
Outpatient Medical Record	2(a)		2(a)	1(b)	1(c)		2(7)		1(e)		
Admission - Admit patients to inpatient status	3(a)(iii)		3(a)(iii)			X				X	
Place patient in Observation	3(a)(ii)		3(a)(iii)			X				X	
History and Physical - Inpatient	3(c)(2)		3(c)(1)		1(c)				1(e)		Time of completion is outlined in 3(c)(ii)(1)-(6); Contents in 3(c)(iii)
Telephone/Verbal Orders	3(d)(1)-(2)		3(d)(1)-(2)			X				X	Must be authenticated within 30 days from discharge: signed, dated and timed
Texting Orders is not permitted	3(d)(3)		3(d)(3)			X				X	
Communicating - Text if using a secure, encrypted platform	3(d)(3)		3(d)(3)			X				X	
Diagnostic and Therapeutic orders	3d)(ii)(1)-(2)		3(d)(ii)(1)-(2)			X				X	
Progress Notes	2(d)(iii)(1)-(3)		3(d)(iii)(1)-(2)		1(c)				1(e)		
Consultations	3(e)		3(e)		1(c)				1(e)		
Discharge	3(f)		3(f)			X				X	APP may write the discharge summary but a physician must countersign
Post-Operative	6(a)		6(a)			X				X	
Use of Abbreviations	4		4		4				4		
Anesthesia	5		5			X				X	

Attachment B: Personnel Authorized to Make Entries into the Medical Record

The following personnel are permitted to make entries into the medical record:

- Care Coordinators
- Certified Chemical Dependency Counselors
- Certified Nurse Practitioner
- Clerical Specialists
- Clinical Nurse Specialist
- Child Life Instructors
- Dentists
- Emergency Medical Technician/Paramedics
- Ethicists
- Exercise Physiologists
- Registered Dieticians
- Organ Procurement Coordinators
- Medical Assistants
- Mental Health Technicians
- Certified Midwives
- Paramedics
- Organ Procurement Coordinators
- Pastoral Care
- Patient Care Technicians
- Pharmacists
- Physical/Occupational/Speech Therapists
- Physicians
- Physician Assistants
- Nurses and nursing assistants
- Professional Counselors
- Psychologists
- Psychology Assistants
- Therapeutic Recreational Specialists
- Radiology Technologists
- Respiratory Therapists
- Scribes
- Social Workers
- Students

*This list is not exhaustive of the individuals permitted to document within the medical record.