Electronic Health Record Content Requirements (Attachment I)

***Some documents may not be applicable depending on payer or treatment rendered.**
Effective Date: 12/09/2019 Rev. 11/17/2021 Rev.11/16/2022

Inpatient (Medical/Surgical)	Day Surgery & Observation
Face sheet/Demographic information	**Face sheet/Demographic information**
Advance Directive (if available**)**	**Advance Directive (**if available**)**
History and Physical (elements included are based on the patient's needs and the setting within which the care is to be given)	**History and Physical** (elements included are based on the patient's needs and the setting within which the care is to be given)
Signed Order(s) by relating to patient care (e.g., confirming that the listed services are medically necessary for diagnosis and treatment of patient)	**Signed Order(s) by Practitioner** relating to patient care (e.g., confirming that the listed services are medically necessary for diagnosis and treatment of patient)
Moderate Sedation or Anesthesia Record (if applicable)*	**Moderate Sedation or Anesthesia Record***
Pre-Post Anesthesia Record (if applicable)*	**Pre-Post Anesthesia Record***
Signed Procedure Note, to include, as applicable: findings; technical procedure(s) used; specimen(s) removed; anesthesia, estimated blood loss, complications, pre-and post-operative diagnosis; name of surgeon(s), assistant(s), and anesthesiologist. *	**Signed Procedure Note,** to include, as applicable: findings; technical procedure(s) used; specimen(s) removed; anesthesia, estimated blood loss, complications, pre-and post-operative diagnosis; name of surgeon(s), assistant(s), and anesthesiologist. *
Operative Record, to include findings, technical procedure(s) used, pre-and post-operative diagnoses, any specimen(s) removed, estimated blood loss, complications, name of surgeon(s), assistant(s), and anesthesiologist. *	**Operative Record,** to include findings, technical procedure(s) used, pre-and post-operative diagnoses, any specimen(s) removed, estimated blood loss, complications, name of surgeon(s), assistant(s), and anesthesiologist. *
Recovery Record, to include criteria met for release from PACU or **Conscious Sedation Record** findings; procedure(s); specimen(s) removed; pre-and post–operative diagnosis; name of surgeon, assistant and anesthesiologist. *	**Recovery Record,** to include criteria met for release from PACU or **Conscious Sedation Record** findings; procedure(s); specimen(s) removed; pre-and post–operative diagnosis; name of surgeon, assistant and anesthesiologist. *
Progress Note/Assessments record of daily rounding and/or other Documentation deemed appropriate based on the patient's condition (all caregivers). This documentation is found in the Progress Notes Report.	**Progress Note/Assessments** record of daily rounding and/or other Documentation deemed appropriate based on the patient's condition (all caregivers). This documentation is found in the Progress Notes Report.
Consultation Report which indicates the reason for consultation, diagnosis, impression and treatment plan (all specialties) Can be dictated or handwritten within the Progress Notes. *	**Consultation Report** which indicates the reason for consultation, diagnosis, impression and treatment plan (all specialties) Can be dictated or handwritten within the Progress Notes *
Ancillary Reports (i.e. lab, radiology, and pathology.)*	**Ancillary Reports (**i.e. lab, radiology, and pathology).*
Medication Administration Record (MAR)	**Medication Administration Record (MAR)**
Nursing Documentation with admission assessment, discharge Planning, learning needs, clinical pathways, care plan(s), focus notes and graphic records.	**Nursing Documentation** with admission assessment, discharge Planning, learning needs, clinical pathways, care plan(s), focus notes and graphic records (if applicable)
Medication List	**Medication List**

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Care Coordination/Social Work Documentation	**Care Coordination/Social Work Documentation**
Discharge Instructions to include medications, follow-up, dietary and activity restrictions, use of any equipment, etc.	**Discharge Instructions** to include medications, follow-up, dietary and activity restrictions, use of any equipment, etc.
Discharge Summary to include diagnoses/procedures* and treatment during the patient's stay	**Discharge Summary** to include diagnoses/procedures* and treatment during the patient's stay
Informed Consent for Invasive procedures*	**Informed Consent for Invasive procedures***
(General) Consent to treat	**(General) Consent to treat**
Release of Information Consent	**Release of Information consent**
Emergency Room Record*	
Care Prior to Arrival (i.e. Chart copy documents, ambulance records)*	

Emergency Room Records	**One Time Outpatient – Ancillary (i.e. Lab, Radiology) – Primarily Diagnostic**
Face sheet/Demographic information	**Face sheet/Demographic information**
Personal Identification and Insurance Card	**Personal Identification and Insurance Card**
(General) consent to treat.	**Signed Order(s) by** Practitioner relating to patient care (e.g., confirming the listed services are medically necessary for diagnosis and treatment of patient).
HIPAA Consent	
Nursing Documentation	**Impression/Results**
Social Work Documentation*	**(General) Consent for Treatment**
Signed Orders by (s) by Practitioner relating to patient care (e.g., confirming the listed services are medically necessary for diagnosis and treatment of patient).	**Release of Information Consent**
	Advanced Beneficiary Notice*
Physician Documentation with diagnostic impressions and treatment given.	
Ancillary Reports (i.e. lab, radiology and pathology)*	
Discharge Instructions (if applicable) to include medications, follow-up, dietary and activity restrictions, use of any equipment, etc.	
Emergency care given to the patient prior to arrival*	
Medication List	

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One Time Outpatient Invasive with Moderate Sedation	One Time Outpatient Invasive without Moderate Sedation and/or Therapeutic
Face sheet/Demographic information **History** & Physical (elements included are based on the patient's needs and the setting within which the care is to be given) **Signed Order(s) by** practitioner relating to patient care (e.g., confirming the listed services are medically necessary for diagnosis and treatment of patient). **Signed Procedure Note,** to include, as applicable: findings; technical procedure(s) used; specimen(s) removed; anesthesia, estimated blood loss, complications, pre-and post-operative diagnosis; name of surgeon(s), assistant(s), and anesthesiologist. **Operative Record,** to include findings, technical procedure(s) used, pre-and post-operative diagnoses, any specimen(s) removed, estimated blood loss, complications, name of surgeon(s), assistant(s), and anesthesiologist. **Sedation or Anesthesia Record** **Progress Notes** and/or other documentation deemed appropriate based on the patient's condition (all care givers) **Ancillary Reports** (i.e. lab, radiology, and pathology)* **Admission Database** with admission assessment, discharge planning and learning needs to include Psychosocial, Spiritual and Cultural Assessment. **Medication List** **Discharge instructions** to include medications, follow-up, dietary and activity restrictions, use of any equipment, etc. **Informed Consent for Invasive procedure** **(General) Consent for Treatment** **Release of Information Consent**	**Face sheet/Demographic information** **History & Physical** (elements included are based on the patient's needs and the setting within which the care is to be given) **Signed Order(s) by** Practitioner relating to patient care (e.g., confirming the listed services are medically necessary for diagnosis and treatment of patient). **Signed Procedure Note,** to include, as applicable: findings; technical procedure(s) used; specimen(s) removed; anesthesia, estimated blood loss, complications, pre-and post-operative diagnosis; name of surgeon(s), assistant(s), and anesthesiologist. * Progress Note and/or other documentation deemed appropriate based on the patient's condition (all care givers) **Ancillary Reports** (i.e.) lab, radiology, and pathology.* **Admission Data** with admission assessment and learning needs to include Psychosocial, Spiritual and Cultural Assessment. **Discharge Instructions** to include medications, follow-up, dietary and activity restrictions, use of any equipment, etc., **Medication List** **Informed Consent for Invasive procedure** **(General) Consent for Treatment** **Release of Information Consent**

Series Outpatient/Continuing Ambulatory Care	Diagnostic and Therapeutic Orders
Face Sheet/Demographic information Initial **History and Physical** (elements included are based on the patient's needs and the setting within which the care is to be given)	**Orders** must be signed, timed and dated with the Practitioner's or House Staff member's ID number; and filed in the health record**.** Practitioners and House Staff may write patient care orders. Physician assistants, nurse s and midwives may write patient care orders according to established department protocols.

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Signed **Order(s) by** Practitioner relating to patient care (e.g., confirming the listed services are medically necessary for diagnosis and treatment of patient). **Visit Note** and/or other Documentation deemed appropriate based on the patient's condition (all care givers) per facility policy. **Summary List,** established by the third visit, to include significant diagnoses, significant operative/invasive procedures, history of adverse or allergic drug reactions, medications prescribed or used by the patient. **Ancillary Reports (i.e.** lab, radiology, and pathology). * **Medication List** **Medical Profile** with Discharge Planning and Learning Needs to include Psychosocial, Spiritual and Cultural Assessment (based on the patient's needs and the setting within which the care is to be given). **Education/Discharge Instructions** to include medication, follow-up dietary and activity restrictions, use of any equipment, etc. **Release of Information Consent** **(General) Consent for treatment** **Informed Consent for Procedure***	Certified Registered Nurse Anesthetists (CRNAs) may write document orders; and other RNs may carry out those orders if the orders pertain to the peri-operative period. CRNAs may only document medication orders on medication sheets, not on prescription pads. A licensed dietitian, acting within the scope of his or her license, may order medical nutrition therapy, laboratory tests and related medical protocols for an individual patient or group of patients. Verbal orders related to restraints may be accepted by designated registered nursing personnel. Verbal orders, if used, must be used infrequently. This means that the use of verbal orders must not be a common practice. Verbal orders pose an increased risk of miscommunication that could contribute to a medication or other error, resulting in a patient adverse event. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering to write the order or enter it into the computer without delaying treatment. Verbal orders are not be used for the convenience of the ordering. Under the supervision of appropriately credentialed providers, verbal and telephone orders may be accepted infrequently by registered nurses, licensed vocational nurses, Pathology Services Genetic Counselor, blood bank scientists, medical laboratory technologists II working in Transfusion Services, and medical assistants for designated medications, laboratory, radiology and diagnostic services. Pharmacists may accept verbal and telephone orders for medication and respiratory therapists may accept verbal and telephone orders for respiratory therapy from appropriately credentialed providers. All House Staff, designated nursing personnel, medical assistants, certified nursing assistants, licensed vocational nurses, respiratory therapists or allied health professionals receiving verbal or document a Verification and "read-back" of the completed order in the health record.

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Transfer from One Medical Service to Another	Death Summary/ Note
Detailed interim service transfer summary addressing the care rendered while responsible for the patient. This summary must include the same level of detail as a discharge summary in the patient's health record. Upon discharge, the medical service dismissing the patient is responsible for documenting the final discharge summary for the health record. The final discharge summary will address the care rendered from the date of service transfer	**In the event of death**, both a Death Summary and a Death note must be documented. For example, The final death note must record the time and circumstances at the time of death. The death note is signed by the completing physician who does the pronouncement. (The death note includes whether the medical examiner was notified, autopsy requested etc...) The Death summary is required by the primary service caring for the patient and includes details to indicate the reason for admission, the findings, course in the hospital and the events leading to death.
Shadow Health records	**Making Corrections to the Health record**
Shadow health records are considered copies of the original health record. A shadow health record must never include original documentation. All original documentation must reside in the electronic health record or in the Health records Department. All shadow record rooms must maintain health records in a locked and secured area.	**All corrections** must be made at or near the time services are rendered.
Order Sets	**RELEASE OF INFORMATION**
All personal and system-wide orders sets must be reviewed by their designated department no later than every three (2) years. The Health records Department will monitor compliance of this standard.	**All requests** for health records from patients or outside agencies must be forwarded to the Health information management Department for processing and release.
Documentation Requirements of Attending Physician	
When members of the House Staff are involved in patient care, sufficient evidence must be documented in the health record to substantiate the active participation in and supervision of the patient's care by the attending physician responsible for the patient. **Attending physicians/residents** must document sufficient evidence in the Health record to substantiate the active participation in and supervision of patient's care when medical students are involved in patient care. The supervising physician/resident must re-document all medical student documentation with the exception of the review of systems and the past family, medical and social history. **In the inpatient setting**, Physician assistants and nurse s are agents of the supervising physician for any medical services delegated by that physician that are 1. Within the physician assistant's/nurse practitioner's scope of practice. 2. Delineated by protocols, practice guidelines, or practice directives established by the supervising physician or department and approved by the Board of Managers. **When allied health professionals**, with the exception of certified nurse midwives, are involved in patient care, the supervising physician will counter sign the following:	

1. Admission orders
2. Admission history and physical 3.Operative/ Invasive report

When a provider of record is not available to complete a record due to death, termination, illness, Team members signature will suffice for signature requirement of other team members provided that the substitute signature is that of a team member of the same level of training or higher. Progress notes shall reflect observation of appropriate protocols in the patient's care.

Medical Records not completed within the established timelines identified in policy 10.03 attachment IV, will be considered delinquent. Any Practitioner with medical records not completed within the documentation timelines will be submitted to the Health Information Management Department for review that may lead to suspension of the Practioner's clinical privileges until such time as the delinquent records are completed.

Hospital At Home (HAH)

At minimum, HAH health record must contain the following:

- Patient Name
- Identification Number
- Date of Service
- Referring Physician
- Consulting Physician
- Provider Organization
- Type of Evaluation Performed
- Informed Consent
- Evaluation results
- Diagnosis/impression
- Recommendation for further treatment
- Other documents requirements are the same as a face- to-face encounter identified in this policy.

Health Record Content and Completion Requirements

Unless there is a pre-approved exception by the Chief Information Officer, all University Health record entries must be transcribed, dictated or typed directly into the University Health electronic medical record using black ink only. University Health approved logos and UH medical record documentation templates may be used when documenting patient care. Copying and pasting external facility templates and logos is not permitted within the UH electronic health record.

REFERENCES/ BIBLIOGRAPHY

University Health Policies:

No. 10.01.05, Medical/Dental Staff Rules and Regulations

The Joint Commission Accreditation Standards 2019 RC.01.01.01, RC.01.02.01, RC.01.03.01, RC.01.04.01, RC.01.05.01, RC.02.01.01, RC.02.01.03, RC.02.03.07, RC.02.04.01

Department of Health and Human Services Center for Medicare and Medicaid Services Interpretive Guidelines 482.23(c) (2) (i)