University Health System
Medical Records Documentation-a Guidance Document
February 22, 2008

Medical Records Management within the University Health System is directed by the UHS Policies, specifically Policy No. 10.03, "Medical Records." Because the processes are complex, the following guidance document has been developed.

Item	**History**
Deadline	within the first 24 hours of admission
Required Content	Chief Complaint Details of present illness, including assessment of the patient's emotional, behavioral, and social status when appropriate. Relevant past, social and family histories, appropriate to the age of the patient. An inventory by body system For children and adolescents, when appropriate An evaluation of the patient's developmental age Consideration of educational needs and daily activities, as appropriate The patient's report or other documentation of the patient's immunization status The family's and or guardian's expectations for and involvement in, the assessment, treatment and continuous care of the patient. An evaluation of the patient's growth.

Readmissions If a complete history has been obtained within a week prior to admission a durable, legible copy of this report may be used in the patient's hospital record, provided there have been no subsequent changes or the changes have been recorded at the time of admission.

When a patient is readmitted within **30 days** for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available. The H&P may be cut and pasted into the current admission with updates as needed. <u>If cut and paste is used, be certain that the information is accurate.</u>

Item	**Physical Examination**
Deadline	within the first 24 hours of admission
Required Content	A current comprehensive physical examination
Details	If a complete physical examination has been performed within **a week** prior to admission, a durable, legible copy of this report may be used in the patient's hospital record provided there have been no subsequent changes or the changes have been recorded at the time of admission.

When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available. The H&P may be cut and pasted into the current admission with updates as needed. If cut and paste is used, be certain that the information is accurate.

Item	**Transfer Summary**
Required Content	When a patient is transferred from one medical service to another, the transferring service is responsible for writing or dictating a detailed interim service transfer summary addressing the care rendered while responsible for the patient. **The summary will include the same level of detail as a discharge summary in the patient's medical record.** Upon discharge, the medical service dismissing the patient is responsible for dictating the final discharge summary for the medical record. **The final discharge summary will address the care rendered from the date of service transfer.**
Deadline	24 hours after transfer

Item	**Discharge Summary**
Required Content	Required elements: Admit and Discharge Dates Provisional diagnosis and reason(s) for admission Principal diagnosis and any additional or associated diagnoses The final progress note If applicable the autopsy report The reason for hospitalization Significant findings Procedures performed and treatment rendered Condition of patient upon discharge Disposition of patient Discharge instructions given to the patient and/or family relating to physical activity, medications, diet, and provisions for follow-up care
Deadline	At or near the time of discharge. Once the medical record has been reviewed (24 hours after discharge),and noted to lack a discharge summary, the notification process begins. Physicians have **48 hours** from notification to complete the discharge summary.

Item **Short Stay Summary**

Required Content A final summation-type progress note will be sufficient as the Discharge Summary in those cases which require less than a 48 hour period of hospitalization.

Deadline At or near the time of discharge.
Once the medical record has been reviewed (24 hours after discharge), and noted to lack a discharge summary, the notification process begins. Physicians have **48 hours** from notification to complete the discharge summary.

Item **Death Summary**

Required Content In the event of death, a summation statement is added to the record as either a final note or as a separate summation. The final note will indicate the reason for admission, the findings and course in the hospital and the events leading to death.

Deadline At or near the time of death
Once the medical record has been reviewed (24 hours after discharge), and noted to lack a discharge summary, the notification process begins. Physicians have **48 hours** from notification to complete the discharge summary.

Delinquent Medical Records

Medical Records become delinquent when deadline for individual items designated above are passed.

Care providers with delinquent medical records will be placed on Administrative Duty until the records have been completed

The process for notification is as follows:

Records less than 21 days old:

Friendly reminders are sent via e-mail and hand delivered to the Coordinator's office.

Records greater than 21 days old:

Delinquent letters are sent via e-mail and hand delivered to the Coordinator's office.

Physicians are text paged on Monday mornings communicating to them; they have delinquent records that are due.

Assignment to Administrative Duty will take place the following Monday.

Physicians have one week to complete delinquent records before any action takes place.

Chief Residents are notified on Wednesdays of residents who have not completed their records.

On the following Friday, the list generated from Monday is updated and provided to Professional Staff Services (PSS) for physicians who are at risk of being assigned to Administrative Duty the following Monday.

On Friday, PSS:

Contacts the physicians via pager, e-mail or telephone with a 48 hour notification of pending Assignment to Administrative Duty.

Notifies the department chairman with 48 hours notification of pending Assignment to Administrative Duty.

On the following Tuesday, the list generated from Friday is updated and physicians are paged once more by the Medical Record Department stating Assignment to Administrative Duty will take place that day at 2:00pm.

At 2:00pm the list is sent to PSS for the Assignment to Administrative Duty process to begin.