DEPARTMENT OF VETERANS AFFAIRS **Policy Memorandum 136-12-30**
South Texas Veterans Health Care System
San Antonio, Texas 78229-4404 **September 24, 2012**

COMPLETION OF MEDICAL RECORDS

1. PURPOSE: To establish policy regarding the processing and completion of medical records at the South Texas Veterans Health Care System (STVHCS). This policy pertains primarily to those stages of medical records processing and completion for which physicians and other providers of care are responsible. It also prescribes policy that must be adhered to by other STVHCS staff involved with the medical record.

2. POLICY: A medical record will be established for every person treated at this facility or at the expense of this agency, regardless of beneficiary status. Medical Records will be accurate and complete in accordance with The Joint Commission (TJC), Current Edition, and Medical Center standards. Medical records will be documented accurately, in a timely manner, and electronic whenever possible; will be readily accessible; and will permit prompt retrieval of patient information. All medical record entries will be legible.

a. **The document requirements are as follows**:

(1) **Signatures**.

(a) All electronic signatures must meet TJC standards and have the following elements (CPRS meets these requirements):

1. Electronically signed by
2. Date
3. Time
4. Signers full name and credential or functional title as assigned by service if credential is not applicable.

(b) All paper documents that are generated for patient care must be dated and signed prior to entry into Vista Imaging.

(c) All documentation including electronic format must be signed/cosigned according to STVHCS Bylaws and Rules of the Medical Staff.

(d) Documentation not signed/cosigned within 30 days from date of entry (or earlier as established by policy or STVHCS Bylawsand Rules of the Medical Staff) will be considered delinquent.

(e) Any electronic or paper documents not signed/co-signed within 60 days from the time of entry will be forwarded to the Medical Records Committee for consideration of administrative completion.

1. Documents approved for Administrative Completion will immediately be forwarded to Chief, HIMS for facilitation of deficiency closure.

2. An addendum will be added to the report indicating approval for administrative closure by the Medical Records Committee referencing the date of the approval in the meeting minutes.

3. The document will be administratively closed with the date of MRC approval minutes referenced.

4. Paper documents that need to be administratively closed will have a note entered in CPRS by the Chief, HIMS or designee stating that the attached document was approved for administrative closure by the Medical Records Committee referencing the date of the approval in the meeting minutes.

(f) No documents of authors in active status will be administratively closed. The author will be expected to sign/co-sign the document.

(g) Inappropriate documentation - samples of inappropriate documentation will be presented to the Medical Records Committee for consideration of being retracted from the record. Items approved will be retracted by the Chief, HIMS or designee and communicated to the chief of the service responsible for the author.

(2) **All in-patient medical records, regardless of the length of stay, will contain at least the following**:

(a) Patient Identification data.

(b) The medical history of the patient.

(c) The report of a relevant physical examination.

(d) Diagnostic and therapeutic orders.

(e) A statement of the conclusions or impression drawn from the admission history and physical (H&P) examination; and a statement of the course of treatment planned for the patient while in the hospital.

(f) Clinical observations, including results of therapy.

(g) Reports of procedures, tests and their results.

(h) Discharge summary.

(3) **Records of patients having surgical procedures will include**:

(a) A preoperative note by the staff surgeon (no more than 30 days prior to the operation).

(b) A note documenting a preoperative, anesthetic evaluation.

(c) Evidence of appropriate informed consent.

(d) A note releasing the patient from the post anesthetic care unit (Recovery Room), when anesthesia was required.

(e) An operative report. If not immediately available for inclusion in the medical record, a progress note with relevant information for continued treatment of the patient.

(4) **A discharge summary**.

(5) **Medical Record Problem List**. Providers will review the Problem List regularly and update as appropriate via direct computer entry. The Problem List will be displayed on the cover sheet of the CPRS.

b. **Definitions**:

(1) **Consolidated Health Record (CHR).** The CHR reflects the skills utilized by both professional and administrative specialties throughout the patient's period of health care. The official and legal medical records is the Computerized Patient Record System (CPRS) including VistA Imaging for documents that cannot be entered electronically . Wherever possible clinical, professional, and administrative staff authorized to make entries in the health record are encouraged to use the electronic system to ensure continuity of care. The CHR can be called the medical record, the patient record, the health record, and the computerized patient record system. The CHR usually contains the following three components:

(a) **The Inpatient Record.** Documenting the diagnosis, treatment or care of a patient during admission to the Extended Care, Acute Care or Observation.

(b) **The Outpatient Record.** Documenting ongoing treatment or care of a patient in a clinic setting.

(c) **The Administrative Record.** Documenting the administrative aspects of a patient.

(2) **Problem List.** The problem list contains significant diagnoses, conditions, procedures, drug allergies and medications including over the counter drugs that are important for the health care team to have readily available in order to provide ongoing care. The Problem List is maintained in the Problem List section of the VistA computerized medical record (CPRS) and should be updated when patient's condition changes.

(3) **Problem.** A medical surgical, psychiatric, or social issue that is of sufficient concern that it warrants listing in the Problem List section of the medical record. Problems are named at their current stage of understanding, however, whenever a clear diagnosis is known, it is listed in preference to a symptom. Problems for listing require an ICD 9 diagnostic code. Problems may be acute or chronic, but their placement in the permanent record requires that they meet the following threshold:

(a) The problem requires ongoing care.

(b) The problem causes an ongoing symptom or disability.

(c) The problem was acute and resolved, but it may affect ongoing care, as in the case of prior surgery.

(4) **Incomplete Record.** An inpatient record will be considered incomplete if it does not contain an H&P, discharge summary or an operative report or an authenticating signature on these documents.

(5) **Delinquent Medical Record.** A medical record is considered delinquent when the chart is incomplete for any reason 30 days following the patient's discharge or date of service for outpatient visits.

3. ACTION:

a. **The Chief of Staff** is responsible for ensuring that discharge summaries and operation reports are completed and signed promptly by the appropriate provider, and for ensuring that the Problem List is reviewed and updated as appropriate.

b. **The Chief, Health Information Management Section (HIMS)** or designee is responsible for reporting monthly the number of delinquent medical records, ensuring the accuracy of the data and timely identification of potential problems, to the Clinical Executive Board through the Medical Record Committee minutes.

c. **Procedures**:

(1) **Discharge Summary**

(a) The Discharge Summary may be entered directly into CPRS or dictated. The discharge summary should be completed (all required data elements are included) and authenticated (co-signed by supervising practitioner) within seven (7) days (as tracked by electronic CPRS signature date stamp) after discharge. In the case of irregular discharge or death the Discharge Summary should be visible in CPRS within 24 hours. It must then be co-signed (authenticated) by a supervising physician within seven (7) days after discharge (as tracked by electronic CPRS signature date stamp).

(b) The required data elements for the Discharge Summary include: (1) The final diagnosis without abbreviations; (2) Concise summarization including the reason for hospitalization and the care, treatment, and services provided; (3) The procedures/operations performed; (4) Items for immediate follow-up (labs, pending reads, etc.); (5) The patient's condition and disposition on discharge; (6) Information provided to the patient and family; (7) Any additions or changes in the patient's medications from what they were taking upon admission (a separate medication reconciliation is required at the time of discharge. A copy is given to the patient); and (8) Provisions for follow-up care.

(2) **H&P**

(a) An H&P is required within 24 hours of admission to the acute hospital, or before surgery, if surgery is on the day of admission (unless it is an emergency). When a patient is readmitted within 30 days for the same or related problem, the previous history and physical with an interval progress note reflecting any subsequent changes may suffice, if it is readily accessible. However, the medical record should always document a current, thorough physical examination prior to the performance of surgery.

(b) An H&P is required within 72 hrs of admission to the Extended Care Unit.

(c) An outpatient who goes to surgery must have a history and physical completed prior to the performance of the surgery, unless it is a documented emergency. The history and physical may be performed up to 30 days prior to the date of surgery providing there is an interval progress note reflecting any subsequent changes that may have occurred.

d. **Progress Notes**. All reports including progress notes must be authenticated with date, name, credentials (if applicable) and title. All professionals on the health care team are expected to write progress notes, including physicians, nurses, dieticians, social workers, and other allied health team members.

e. **Problem List**:

(1) Each patient record will contain an up-to-date Problem List.

(2) Primary care providers are responsible for reviewing problem lists and updating them. A problem list must be initiated by the third primary care visit.

f. **Informed Consent**: For the purposes of documenting informed consent for clinical treatments and procedures that require signature consent, the VA-authorized consent form refers to the use of the iMedConsentTM software program to conduct the informed consent discussion, capture electronic signatures, and file the completed document electronically in the patient's record. Printed VA Form 10-431a, Consent for Clinical Treatment or Procedure and VA Form 10-431b, Consent for Transfusion of Blood Products is authorized for use if: (1) The patient declines to use the electronic signature pad, or (2) There is a temporary system failure that prohibits proper use of the iMedConsentTM software or hardware,

or (3) The patient is giving consent by telephone or fax, or (4) The use of the equipment that supports the iMedConsentTM software program would introduce infection control issues.

g. **Operative Reports**:

(1) **An Immediate Post-operative Note** must be entered in the patient's health record by the surgeon immediately following the surgery and before the patient is transferred to the next level of care. The only time an Immediate Post-operative Note is not necessary is when an Operative Report (R.12.10) is entered into CPRS and authenticated by the supervising practitioner immediately following the surgery and before the patient is transferred to the next level of care. The Immediate Post-operative Note must include: 1. Pre-operative diagnosis, 2. Post-operative diagnosis, 3. Technical procedures used, 4. Surgeons, 5. Anesthesia, 6. Blood loss, 7. Findings, 8. Specimens removed, 9. Complications, and 10. Plan. The Immediate Post-operative note should include when appropriate: 11. Drains and 12. Tourniquet time.

(2) **Operative Report**. An operative report must be entered into the health record or dictated by the operating surgeon or supervising practitioner immediately following surgery and before the patient is transferred to the next level of care. In addition to the required data elements for the Immediate Post-operative Note (R.12.9) the body must include the indication(s) for the procedure, names of the supervising practitioner, primary surgeon, assistants; and the presence and/or involvement of the supervising practitioner. The Operative Report when dictated in addition to an Immediate Post-operative Note must be authenticated by the supervising practitioner within 30 working days of transcription being completed. The level of supervision must be documented.

(3) **Diagnostic and Therapeutic Procedure Reports**. Detailed reports of diagnostic and therapeutic procedures performed in locations other than the operating room must be documented in a progress note by the practitioner performing the procedure, and must contain: the name of the procedure; the name of the person performing procedure; details of performance; major findings and conclusions; whether or not tissue was removed; any complications; a signature, a title, and a date.

(4) The physician responsible for anesthesia care or his/her designee makes decisions regarding the management of the patient and the evaluation of the patient's condition for discharge. Patients are released from the PACU by written order of the Anesthesia Service. A postanesthesia note is made in the Progress Notes describing the patient's physiologic condition upon anesthesia release from the PACU. A postanesthesia note must include: vital signs and level of consciousness; medications and blood and blood components; any unusual events or post-operative complications including blood transfusion reactions; and the management of such events. Nurse anesthetists so credentialed, and acting for the Chief, Anesthesiology Service, may release patients from PACU using those criteria established and will enter a PACU release note in the patient's record.

h. **Orders**

(1) All practitioners who hold clinical privileges and house staff who are graduates of medical, dental, podiatry, optometry or osteopathic schools may write orders in the medical records. Physician assistants, nurse practitioners, clinical pharmacists, clinical nurse specialists, and certified registered nurse anesthetists assigned to clinical services with a Scope of Practice approved through the Medical Staff Professional Standards Board may write orders at the STVHCS.

(2) Orders will be entered by the provider into the computerized medical record system or if not available, written on the Doctor's Order Sheet, VA Form 10-1158.

i. **All electronic reports** will be uploaded into the VistA system on regular intervals during the day. The incomplete record tracking system will be updated to reflect the status of all reports that are being tracked.

j. **Electronic signatures** are appropriate for use and are secured by unique access and verify codes and all staff must acknowledge their understanding of the secure nature of these codes and their appropriate use.

4. REFERENCES: VHA Handbook 1907.1 dated April 15, 2004 and TJC, Current Edition

5. RESPONSIBILITY: Chief, Medical Administration Service (136)

6. RESCISSIONS: STVHCS Policy Memorandum 136-10-30 dated July 29, 2010

7. RECERTIFICATION: September 2017

(Original signature on file)

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Director

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