

ALABAMA QUALITY ASSURANCE FOUNDATION

GENERAL MEMORANDUM 96/99-10

FOR IMMEDIATE DISTRIBUTION TO YOUR MEDICAL STAFF, UR/QA DEPARTMENTS, MEDICAL RECORDS DEPARTMENTS, AND OUTPATIENT SERVICE DEPARTMENTS

TO: Hospital Administrators, Chiefs of Staff--All Alabama Hospitals, Outpatient Departments, and Ambulatory Surgery Centers

FROM: Robert G. Sherrill, M.D., Medical Director

DATE: November 12, 1997

SUBJECT: DOCUMENTATION GUIDELINES FOR MEDICAL RECORDS

I. PURPOSE

The purpose of this General Memorandum is to provide further clarification to General Memorandum 93/96-20 referencing documentation guidelines for inpatient and ambulatory medical records.

II. DOCUMENTATION GUIDELINES

In general, the hospital medical record must contain information to justify the admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services. All entries must be legible and complete and must be authenticated and dated promptly by the person (name and discipline) who is responsible for ordering, providing or evaluating the services furnished.

Ambulatory Surgery Centers (ASC) and Hospital Outpatient Departments (HOPD) must also maintain a medical record for each patient. These records must be accurate, legible and promptly completed. Specific requirements for ASC and HOPD records are found in the attached specific section.

III. DOCUMENTATION CLARIFICATION

The most common problem encountered in the review process has been consistently identified as inadequate medical record documentation. With the increasing instances

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of frequent visits to ambulatory centers for related care, AQAF has revised the outline of its requirements for ambulatory medical record documentation.

These requirements are not only based on the belief of the fundamental reason for maintaining an adequate medical record is its contribution to high quality of medical care, but also the minimum standard as defined in the Federal Register for hospitalized patients at 42 CFR 482.24(c) and for ambulatory surgery center patients at 42 CRF 416.47(b).

- IV.** Please distribute copies of these guidelines to your medical staff and utilization/quality assurance personnel. Comments on the guidelines and documentation requirements will be welcomed by our staff. Please address questions or comments to Pat Burgess R.N. at Ext 3222 or to the Medical Director's office at Ext 3103.

cc: Provider contact person; AQAF Board of Directors; J. Barnett & F.Richards, M.D., FMQAI; Patty Rawlings, PO/DHHS; J.Michael Horsley/ALAHA; Cary Kuhlman/MASA; Frazer Rolen/ALAHA-Birmingham

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**GUIDELINES for
MEDICAL RECORD DOCUMENTATION**

**Medical Record Documentation for
Hospitals, Ambulatory Surgery Centers, and
Hospital Outpatient Departments**



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DOCUMENTATION of HOSPITAL MEDICAL RECORDS

1. **Admission Notes/H&P:**

Upon admission to the hospital, a patient's medical record should include both an admission note and a complete history and physical. Information obtained prior to admission must be included in the medical record if the information is to be relied upon to document the medical necessity and appropriateness of the admission, surgery or other services provided. The responsible physician must record and authenticate a pre-operative diagnosis prior to surgery. An admission note signed, dated and recorded at the time of admission, pertinent recent patient history, current physical findings, a provisional diagnosis and plan of care.

2. **History & Physical:**

The H&P examination must be recorded in the record within 48 hours after admission (or as dictated by hospital bylaws) unless surgery is to be performed in less than 48 hours in which case the H&P must be recorded and included in the medical record prior to surgery. In the case of an emergency surgery, the H&P must be recorded and included in the record as dictated by the hospital bylaws.

Each medical history should include recent (24 hour) pertinent studies or observations performed prior to the admission if they support or justify the admission. The H&P should also include the chief complaint, present illness, past history including current medications, dosage and drug allergies, summary of past history, family and social history and a review of body systems pertinent to the case.

The Physical Examination:

A comprehensive current physical examination covering each of the body systems with particular attention to the system involved and with the chief complaint is required. All pertinent normal abnormal finding and impressions should be included and signed by the responsible physician.

3. **Progress Notes:**

Progress notes must be dated, signed and recorded daily by the responsible physician. These notes should reflect clinical observations, changes in condition, explanation for and results of treatment, family/patient wishes, and do not resuscitate notes. Abnormal values and rational for medical management must be fully explained.

4. **Orders:**

Physician orders need to be dated, timed and signed within 24 hours (or as defined by

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hospital bylaws) after verifying the accuracy of such orders. Special attention needs to be directed to the verbal/telephone orders.

5. **Operative Reports:**

Operative reports must be dictated or written in the medical record immediately following surgery and must contain a description of the findings, technical procedure used, a description of specimens removed, the pre- and post-operative diagnosis and the name of the surgeon and filed in the medical record. In addition, an operative progress note, including all pertinent information must be recorded by the surgeon and placed in the medical record immediately after surgery.

6. **Attending Physician Responsibility on a Teaching Service:**

- * All patients should be admitted to an attending physician who is ultimately responsible for the medical care.
- * The H&P and discharge summary should be reviewed and signed by the attending physician.
- * An attending physician must make daily rounds on each patient with house staff and indicate his presence by signature on the record or a brief note written and signed by him/her on the record.
- * The attending physician should place an admit note on the chart within 24 hours of the admission describing the reason for the admission and management plans.
- * All medical students orders must be countersigned by the attending physician and/or licensed resident.

7. **Consultations:**

A written consultation report must be included in the medical record. The consultation report must include a written opinion of the consultant, the consultant's findings upon examination of the patient and the consultant's recommendations. It should be made clear in the record if the consultant is merely rendering an opinion and suggestions on therapy and/or procedures and/or if assuming the responsibility for the care of the patient.

8. **Pathology Report:**

Pathology report of tissue or body fluids removed must be present in the record.

9. **Reaction:**

Documentation of complications, hospital acquired infections and unfavorable reactions to drugs and anesthesia must be present.

10. **Informed Consent:**

Properly executed informed consent forms for procedures and treatments as specified by the medical staff, or be Federal or State law, must be included in the medical record.

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11. **Discharge Summary:**

A discharge summary should be placed on the chart, preferably at the time of discharge, however, it must be present on the chart within a reasonable number of days as defined by the medical staff bylaws. The discharge summary should include the reason for the admission, the significant findings, the procedures and treatment, the condition of the patient at discharge as well as the instructions to the patient and the family including the physical activity, diet, medications, dose and follow up. In the event of the patient's death, a summary statement should be added to the record which indicates the events leading up to the patient's demise. If the patient is transferred to another facility, a transfer summary including a copy of the record should be forwarded with the patient to the receiving hospital. For the patients in the hospital less than 48 hours and/or patients in which a short stay record is used, pertinent laboratory and radiographic findings and dictation of the hospital course and disposition may be included in the H&P as one document.

12. **Electronic Signatures:**

Federal regulations permit the use of "computer entry" to authenticate all medical record documentation when permitted by the hospital and medical staff policies. Alpha/numeric or biometric identifying systems may be used. [When computer entries are used, the hospital will maintain a list of computer codes and written signatures. This list must be readily available yet maintained under adept safeguards. Facility acceptability will be determined by the intermediary.]

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AMBULATORY SURGERY DOCUMENTATION

Minimum documentation requirements for ambulatory surgery records have been established by the Health Care Financing Administration (HCFA) and are provided here for your examination. Few changes (*italicized*) have been made in the essentials as outlined in our previous General Memorandums dated August 5, 1994 (# 93/96-20).

Ambulatory Surgery Centers (ASC) and Hospital Outpatient Departments (HOPD) must maintain a medical record for each patient that is accurate, legible and promptly completed. The record must contain a history and physical (H&P) examination appropriate for the surgery/procedure to be performed including the chief complaint. *If the H&P is performed within the past 60 days, but not on the day of surgery, a pre-operative note on the day of surgery to reflect the patient's current status is necessary. An interval notation reflecting changes from a previous examination may be used in cases of frequent returns for the same or related problem. The original H&P information should be copied and placed with each medical record (see attached examples under "Discussion").* The extent of the physical examination required will depend upon the procedure to be performed and the anesthesia used. The record must contain the results of the examination, procedures and treatment which together with indications/symptoms establish justification for the surgery/procedure. The H&P may be performed by the referring physician or the surgeon. The surgeon must countersign an examination performed by assistants who may be authorized by state law to perform an examination under his supervision.

The record must contain all medications, along with their dosage the patient is taking, allergies, comorbid conditions and informed consent.

Pre-operative vital signs, preferable taken within an hour prior to surgery/procedure, are required. Temperature is optional for short procedures (under 20 minutes). Intra and post-operative vital signs are required where the condition of the patient would warrant obtaining this information. Included in the essentials is a pre and post-op statement of the patient's mental assessment.

An operative note providing a description of the indication, findings, procedures and pathology reports, if available, is required.

A discharge note which may be included with the operative note, must contain instructions, medications and dosage, follow-up visit, care arrangements, referrals, consultations and other significant events such as the transfer of a patient. Documentation should support the procedure codes (HCPCS/CPT) billed. Documentation elements for ambulatory surgery are included on the following page. A brief H&P form and required documentation elements have also been provided. This form is not mandatory but is provided as an example for the medical staff as a reference tool.

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DOCUMENTATION ELEMENTS FOR AMBULATORY SURGERY

ELEMENT	DOCUMENTATION
GENERAL	<p>A current H&P (within 30 days) must be performed on any patient in which ambulatory surgery/procedures are to be performed. The history and physical may be performed by the referring physician, the attending physician, or an assistant an assistant who may be authorized by state law to perform an examination. If H&P is performed within 30 days but not on the day of surgery, a pre-operative note on the day of surgery to reflect the patient's interim and current status is necessary.</p> <p>The original H&P information should be copied and placed with each medical record. The extent of the physical examination required will depend upon the procedure to be performed and the anesthesia used. The following guideline will assist you in making this determination.</p> <ol style="list-style-type: none"> 1. <u>No anesthesia, or topical -local or regional block</u> <ol style="list-style-type: none"> a. Assessment of mental status, vital signs; b. An examination specific to the procedure proposed to be performed and any co-morbid condition. 2. <u>I.V. sedation</u> <ol style="list-style-type: none"> c. Both a. b., and; d. Examination of heart and lung by auscultation. 3. <u>General, spinal, or epidural anesthesia</u> <ol style="list-style-type: none"> e. Both a., b., d., and; f. A complete examination. <p>Pre-procedure notes on patients undergoing spinal or general anesthesia must include an anesthesia examination including the anesthesia planned and risk of anesthesia by a person qualified to administer anesthesia. This information may be included in the operative note.</p>
PRE-OP EVALUATION	<p>In addition to the above noted documentation requirements, a pre-operative assessment should include:</p> <ul style="list-style-type: none"> • Indications/ symptoms to justify procedures • Informed Consent • List of current medications and dosages of each • Known allergies/medication reactions • Existing co-morbid conditions (if any) <p><i>[Consultation when indicated--clearing patient for surgery]</i></p>
PHYSICAL	<p>The physical examination required is most often on the extent of the surgical procedure and the anesthesia used. The information under "GENERAL" above provides a baseline for the extent of the examination required. All patients should have vital signs recorded initially, however, intra-operatively and post-operatively vital signs are only necessary when the patient's condition reflects the need. A pre-operative temperature is not required for colonoscopy or UGI endoscopy, and, in general, for procedures of short duration, i.e., 20 minutes.</p>
LAB & X-RAY	<ul style="list-style-type: none"> • Testing according to facility standards and appropriate to the procedure to be performed. • All results must be normal or addressed. • All reports should have a date and time documented.
ANESTHESIA	<ul style="list-style-type: none"> • Anesthesia risk considerations and anesthesia planned are to be recorded. These may be included in the operative note.
SURGICAL REPORT (OP-NOTE)	<ul style="list-style-type: none"> • <i>[Surgeon(s), descriptions of indications, findings, procedures and pathology report if available are required. May include the discharge note with the operative note.]</i>

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POST-OP DISCHARGE AND EDUCATION	<ul style="list-style-type: none">• Documentation of intervention or explanation of abnormalities which occurred intra-operatively or post-operatively are required.• Statement of medical stability and mental assessment.• Care arrangements and to whom released.• Instructions - medications - follow-up visits - transfers to another care setting or admission should be noted.
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HISTORY & PHYSICAL FOR ASC PATIENTS

PROCEDURE:

INDICATIONS FOR PROCEDURE: (Include symptoms, prior W/U, risk assessment)

PAST MEDICAL HISTORY:

Allergies/Reactions _____ Co-morbid Conditions _____
Medications and dose _____ Lab/x-ray _____

PRESENT LAB/X-RAY: (Appropriate to procedure)

Lab _____
X-ray _____

PHYSICAL EXAM: (Limited to appropriate organ system-include heart, lung auscultation if other than local anesthesia used)

MENTAL STATUS _____
HEENT _____ ABD. _____ EXT _____
CHEST _____ CVS _____ OTHER _____

PRE-OP VITAL SIGNS: B.P. _____ TEMP. _____ P. _____ R. _____

POST-OPERATIVE: MENTAL STATUS _____
VITAL SIGNS (Not necessary unless patients condition indicates)

NARRATIVE OF OPERATIVE FINDINGS:

DISCHARGE PLAN & INSTRUCTIONS:

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PATIENT OR FAMILY MEMBER SIGNATURE ACKNOWLEDGING DISCHARGE PLANS	M.D. SIGNATURE AND DATE
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NOTE: This form is not mandated- presented as an example only

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DISCUSSION

The following examples are typical of documentation problems received by the Alabama Quality Assurance Foundation offices which necessitated this guideline modification.

EXAMPLE #1: Debridement/Wound Care

A patient returns to the Wound Care Center several times over a period of 2 months for wound debridement and whirlpool cleansing of pressure ulcer. The initial visit occurred on 6/30/97 in which a complete H&P was documented by the physician. Subsequent visits were scheduled every week for the first month and then every two weeks thereafter. An interval notation at each visit which reflects changes from the 6/30/97 examination must be documented in lieu of another complete H&P. The original H&P information should be copied and placed with each medical record.

EXAMPLE #2: Second Cataract Surgery

A patient present to the ASC for extracapsular cataract removal with intraocular lens implant of the right eye on 7/7/97. The same procedure is scheduled for 8/11/97 on the left eye. A complete H&P was documented by the surgeon on 7/7/97. An interval notation reflecting changes from the 7/7/97 examination must be documented at the 8/11/97 visit in lieu of another complete H&P. Information specific to the operative site must be included. The original H&P information should be copied and placed with each medical record.

EXAMPLE #3: Epidural Anesthetic and/or Steroid Injections

A patient presents to the hospital outpatient department with c/o chronic back pain. The physician performs an initial H&P on the patient on 5/25/95 prior to an L3-4 injection of Depomedrol and Xylocaine. The patient returns to the outpatient department several times within the next 3 months for repeat injections. Interval notations reflecting changes from the previous examination must be documented on each visit. The original H&P information should be copied and placed with each medical record.

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