LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
- SHREVEPORT

MEDICAL RECORDS
CONTENT/DOCUMENTATION

Purpose:
To define the components of the paper and electronic medical record to support the patient’s diagnosis and justify the care, treatment and services provided.

Policy:
A. All medical record entries, including handwritten and electronic, must be legible, complete, dated, timed and authenticated by the person responsible for providing or evaluating the services provided, consistent with hospital policies and procedures.

B. Content of the Medical Record

1. The content of the medical record, which includes written and electronic documentation, must enable:
   - the practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient’s condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient’s response to treatment;
   - a consultant to render an opinion after a patient examination and review of the medical record;
   - another practitioner to assume patient care at any time;
   - and the review of information required for case management, utilization review, quality review, transfer recommendations, etc.

2. The medical record contains the following demographic information:
   a. The patient’s name, address, date of birth, and the name of any legally authorized representative;
   b. The patient’s sex
   c. The patient’s race and ethnicity
   d. The legal status of any patient receiving behavioral health care services
   e. The patient’s language and communication needs, including the preferred language for discussing health care issues.

3. The medical record contains the following clinical information:
   a. The reason(s) for admission for care, treatment and services
   b. The patient’s initial diagnosis, diagnostic impression(s) or conditions(s)
   c. Any findings of assessments and reassessments
   d. Any allergies to food or latex
   e. Any allergies to medication
   f. Any conclusions or impressions drawn from the patient’s medical history and physical examination
g. Any diagnoses or conditions established during the patient’s course of care, treatment, and services
h. Any consultations reports
i. Any observations relevant to care, treatment and services
j. The patient’s response to care, treatment and services
k. Any emergency care, treatment and services provided to the patient before his or her arrival
l. Any progress notes
m. All orders
n. Any medications ordered or prescribed
o. Any medications administered, including the strength, dose, frequency and route
p. Any access site for medication, administration devices used and rate of administration
q. Any adverse drug reactions
r. Treatment goals, plan of care, and revisions to the plan of care
s. Results of diagnostic and therapeutic tests and procedures
t. Any medications dispensed or prescribed on discharge
u. Discharge diagnosis
v. Discharge plan and discharge planning evaluation

4. The medical record contains the following information as needed to provide care, treatment and services:
   a. Any advance directives
   b. Any informed consent, when required by hospital policy
   c. Any records of communication with the patient, such as telephone calls or email
   d. Any patient-generated information

5. The medical record of a patient who receives urgent or immediate care, treatment and services contains all of the following:
   a. The time and means of arrival
   b. Indication that the patient left against medical advice, when applicable
   c. Conclusions reached at the termination of care, treatment and services, including the patient’s final disposition, condition and instructions given for follow-up care, treatment and services
   d. A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment or services.

6. A summary list (Snapshot) is initiated for the patient by his or her third visit. The patient’s summary list contains the following information:
   a. Any significant medical diagnoses and conditions
   b. Any significant operative and invasive procedures
   c. Any adverse or allergic drug reaction
   d. Any current medications, over-the-counter medications and herbal preparations

The patient’s summary list is updated whenever there is a change in diagnoses, medications or allergies to medications and whenever a procedure is performed.
The summary list is readily available to practitioners who need access to the information of patients who receive continuing ambulatory care services in order to provide care, treatment and services.

C. Chart Rules and Regulations

1. History and Physical Examination
   a. A complete history and physical examination shall be documented and filed on the patient’s medical record within the first 24 hours after admission for any procedure requiring consent or involving or requiring anesthesia services.
   b. If a history and physical examination has been completed within thirty (30) days prior to admission or performing a procedure requiring consent, a signed, durable, legible copy of this report may be used in the patient’s medical record provided there has been no subsequent changes. An updated entry must be documented within 24 hours after admission for any procedure requiring consent or anesthesia services, documenting any changes in the patient’s condition when the medical history and physical examination are completed within 30 days before admission. Upon admission, the patient shall be examined and the following entered into the electronic health record – patient examined, H & P reviewed and no changes noted or pertinent change includes the following.
   c. In the case of an emergency a preoperative note is recorded prior to the surgery/invasive procedure. In addition, the preoperative diagnosis & indicated diagnostic tests are completed and recorded in the patient's medical record before surgery/invasive procedure.
   d. The history should include the following:
      1) Chief complaint
      2) Present illness
      3) Relevant past, family, and social histories, appropriate for age (including tobacco, alcohol and other substance use)
      4) Inventory of body systems, including the presence of preexisting medical devices (e.g. indwelling catheter, central line), the devices’ condition and current impact on the patient; ordering the appropriate lab to verify preexisting infections, etc.
      5) Evaluation of patient's developmental age (pediatric/adolescent records only)
      6) Consideration of educational needs and daily activities (Pediatric/adolescent records only)
      7) Immunization status (Pediatric/adolescent records only) and for the adult patient with a preliminary diagnosis of Heart Failure or Pneumonia, the vaccine history related to pneumococcal and influenza shall be documented
      8) Family and/or guardian's expectation for and involvement in, the assessment, treatment, and continuous care of the patient (Pediatric/adolescent records only)
      9) Head circumference until fontanels close (pediatric) as appropriate to patient’s age & needs
      10) Length/weight within the past 7 days (pediatric/adolescent)
   e. The physical examination shall reflect the following minimum documentation requirements: A general multi-system examination and/or an extended examination of the affected body area(s) and other symptomatic related organ(s).
   f. The recorded history and physical examination must be authenticated by a practitioner privileged to do so.
g. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record.

2. History and Physical Examination (Outpatient Surgery)

a. The history and physical information for outpatient surgery may be completed by a qualified physician or oral surgeon, but the individual performing the procedure MUST enter the following into the electronic health record (at minimum):
   1) An evaluation note regarding the patient’s overall condition and
   2) Information regarding the operative/procedure site

b. The outpatient history must include the following for outpatient surgery:
   1) Indications/symptoms for surgical procedure;
   2) Current medications (dosages/frequency)
   3) Any known allergies, including medication reactions
   4) Existing co-morbid conditions, if any.

c. The extent to which the patient’s physical status must be entered is to be reflective of the type of anesthesia planned and/or given, according to the following:
   1) No Anesthesia or Local/Topical or Regional Block:
      a) Vital signs
      b) Assessment of mental status; and
      c) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
   2) Procedural Sedation:
      a) Vital signs
      b) Assessment of mental status
      c) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
      d) Examination of heart and of lungs by auscultation.
      e) Allergies
      f) Family history of anesthesia problems
      g) Medication history
      h) Abnormal lab results

4. Deep Sedation, General, Spinal or Epidural Anesthesia:
   **Complete Physical Examination**
   **Note:** Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

5. The medical record contains the following postoperative information:
   a. The patient’s vital signs and level of consciousness
   b. Any medications, including intravenous fluids and any administered blood, blood products and blood components
   c. Any unanticipated events or complications and the management of those events.
d. The patient was discharged from the post-sedation or post anesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. The medical record contains the use of approved discharge criteria that determine the patient’s readiness for discharge.

e. The postoperative documentation contains the name of the licensed independent practitioner responsible for discharge.

6. Progress Notes

a. The admission progress note should summarize the present illness, pertinent past history, the pertinent physical and laboratory findings, the initial impressions of the physician and the initial diagnostic and therapeutic plan.

b. Progress notes (reassessments) should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition, the result of treatment and plans for future care.

c. An authenticated progress note is required daily to document medical necessity and acute level of care.

d. Progress notes must reflect the involvement of the attending physician in the patient’s care.

e. All progress notes must be signed, dated and timed.

7. Consultations

Consultation reports shall be a part of the patient’s medical record and shall show evidence of a review of the patient’s record by the consultant, pertinent findings on examination of the patient, the consultant’s opinion, the consultant’s recommendations and the signature of the consultant.

a. An order for a routine consultation shall be entered into the electronic medical record. The reason for the consultation must be entered. The physician or his/her designee requesting the consultation is responsible for contacting the service to be consulted. A monthly listing of designated consultants for each Clinical Service is published and distributed each month to all patient care areas for utilization by the requesting physicians. Problems obtaining consultations should be directed to the attention of Hospital Administration. Inpatient consultations shall be answered within 24-hours.

b. An order for an outpatient ambulatory referral shall be entered into the electronic medical record. The outpatient ambulatory referral does not require physician to physician contact.

c. An order for an Emergency or 'stat' consultation shall be entered into the electronic medical record. The physician will notify the Clinical Service directly of the need for the consultation, giving the patient's name and location. Emergency or "stat" consultations should be answered within one hour of notification.

8. Informed Consent

Informed consent must be obtained by a physician prior to any invasive and/or operative procedure from each patient or the patient’s legally authorized representative. Informed consent implies that the patient has been informed of the procedure to be performed, the risks involved, any alternative procedures and the intended outcome. Informed consent is documented by making:

a. appropriate progress notes in the patient's medical record and

b. by obtaining the signature of the patient or his/her legal representative on the approved consent form. The progress notes should reflect the content of the discussion with the
patient and the physician's evaluation of the patient's understanding and response to the information provided.

9. Operative Reports
   a. An operative or other high-risk procedure report is entered into the electronic health record or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a brief progress note is entered into the medical record. The progress note and the dictated operative report must include the following:
      1) The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
      2) The name of the procedure performed
      3) A description of the procedure
      4) Findings of the procedure
      5) Any estimated blood loss
      6) Any specimens removed
      7) The Postoperative diagnosis
   b. The surgeon must authenticate the completed operative report as soon as possible following surgery.

10. Pre and Post Sedation/Anesthesia Assessment
    There must be a pre-sedation or pre-anesthesia assessment documented in the patient's medical record before initiating operative or other high-risk procedures, including those that require the administration of deep sedation or anesthesia. The pre-anesthesia/pre-sedation assessment is entered by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.
    The medical record contains the following postoperative information:
    a. The patient’s vital signs and level of consciousness
    b. Any medications, including intravenous fluids and any administered blood, blood products and blood components
    c. Any unanticipated events or complications and the management of those events.

11. Diagnostic and Therapeutic Orders (Verbal and Telephone Orders)
    a. All orders for medications and treatment shall be entered by members of the medical staff and other practitioners involved in the care of the patient who may have been authorized to do so by the granting of privileges.
    b. Verbal orders shall be minimized. Verbal and telephone orders shall be accepted by the following healthcare professionals – registered nurses, registered pharmacist licensed respiratory therapists, certified/registered EEG technologists, physical/occupational therapists, licensed dietitians, medical technologists/technicians, radiology technologists, nuclear medicine technologists, radiation therapists, and physician assistants. The healthcare professional accepting the verbal order must read the order back to the prescribing physician and enter the ‘read back’ into the electronic health record.
    c. Physician extenders (physician assistants, advance practice nurses, etc.) may accept verbal orders from their supervising physician; the supervising physician shall authenticate these verbal orders (paper or electronically) within 24 hours for inpatients and hospital emergency departments and 72 hours in all other cases.
12. Do Not Resuscitate (DNR)

DNR orders must be authenticated by an attending physician.

13. Transfers

When a patient is transferred within LSUHSC-S, from one service to another or from one level of care to another, a transfer note shall be entered into the electronic health record. This note should briefly describe the patient’s condition at the time of transfer and the reason for the transfer.

14. Discharge Summary

a. The discharge summary should be completed before or shortly after the time of inpatient discharge from the facility and should follow the following approved format:
   1) Patient Name
   2) Medical Record Number
   3) Hospital Service
   4) Attending/Resident Physician
   5) Referring Physician or Clinic
   6) Admission/Discharge Date
   7) Discharge Diagnosis (documented without the use of abbreviations or symbols):
   8) Reason for Hospitalization
   9) Significant Findings (physical and laboratory)
   10) Hospital Course
   11) Procedures performed and care, treatment and services provided
   12) Condition on discharge (measurable comparison with condition on admission - able to swallow with minimum difficulty; afebrile and ambulating with crutch, no signs of infection, etc.)
   13) Information provided to the patient and family (i.e., diet, medication, activity and follow-up, other discharge instructions)

b. A final progress note can be substituted for the discharge summary only for those patients with problems and interventions of a minor nature who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetric deliveries. The progress note documents the patient’s condition at discharge, discharge instructions and required follow up.

c. In the case of death, the discharge summary is replaced by a death summary stating essentially the same information, plus a summary of events immediately prior to death, including the cause of death as well as the date and time of death.

d. In the case of a patient leaving “Against Medical Advise” (AMA), the summary or progress note should include the same information, including events leading up to the patient’s departure.

e. All discharge summaries shall be authenticated by the responsible practitioner.

15. Countersignatures

All written or electronic entries by physician extenders (physician assistants, advance practice nurses, etc.) shall be reviewed, and authenticated by the supervising physician within 24 hours for inpatients and within 72 hours for clinic and other practice settings. The physician extender (physician assistant, advance practice nurse, etc.) and the supervising physician shall insure that all activities, functions, services, treatment measures, medical devices or medications
prescribed or delivered to the patient by the physician extender are properly documented into the electronic health record.

16. Scanned Documents
Paper documents may be scanned into the electronic health record under Media Manager. Documents may be scanned to the Patient, Encounter or Order level. Documents should be scanned with the magnification of Actual size. Other options may cause the image to appear blurry and unreadable.

17. Signature Stamps
Rubber signature stamps are not authorized for use in the patient's medical records.

Reference:  IM.6.10 – IM.6.60
Hospital Policy 6.13 – Telephone and Verbal Orders
Hospital Policy 5.16 – Informed Consent
Hospital Policy 5.19 - DNR
Hospital Policy 5.22 – Advance Directives
Hospital Policy 5.24 – Discharge Policy
Hospital Policy 5.26 – Conscious Sedation

Hospital Administrator

11/21/12

Date

Approved by Clinical Board:  8/15/00, 10/21/03, 1/16/07, 9/16/08, 4/20/10, 6/15/10, 11/20/12
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