LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MEDICAL RECORDS CONTENT/DOCUMENTATION

Purpose:

To define the definitions, capture, analysis, transformation, transmission and reporting of individual patient specific data and information related to the process(es) and/or of the outcome(s) of the patient's care. The organization has a complete and accurate medical record for every individual assessed or treated. Every medical record entry is dated; its author identified and when necessary, treatment noted.

Policy:

A. Content of the Medical Record

1. Hospital inpatient medical records and outpatient surgery records are required to contain at least the following:

   a. The patient's name, address, date of birth, sex and name of any legally authorized representative;
   b. The legal status of patients receiving mental health services;
   c. Emergency care provided to the patient prior to arrival, if any;
   d. Documentation and findings of the patient's assessment;
   e. Conclusions or impressions drawn from the medical history and physical examination;
   f. The diagnosis, diagnostic impression or condition;
   g. The reason for admission or care, treatment and services;
   h. The goals of treatment and the treatment plan;
   i. Evidence of known advance directives;
   j. Evidence of informed consent when required;
   k. Diagnostic and therapeutic orders;
   l. Diagnostic and therapeutic procedures and test results relevant to the management of the patient's condition;
   m. Operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
   n. Progress notes made by authorized individuals;
   o. Reassessments and plan of care revisions, when indicated;
   p. Relevant observations;
   q. Response to care, treatment and services provided;
   r. Consultation reports;
   s. Allergies to food and medicine;
   t. Every medication ordered or prescribed;
u. Every medication dispensed on discharge;
v. Every dose of medication administered and any adverse drug reaction;
w. All relevant diagnoses/conditions established during the course of care, treatment and services;
x. Documentation of referrals and communications made to external or internal care providers and to community agencies;
y. Conclusions at termination of hospitalization;
z. Discharge instructions to the patient and family; and
aa. Discharge summaries or a final progress note or transfer summary.

2. Ambulatory care records generated in one of the hospital sponsored clinics require the following:

a. Patient identification
b. Relevant history of the illness or injury and of physical findings
c. Diagnostic and therapeutic orders
d. Clinical observations, including the results of treatment
e. Reports of procedures and tests and their results
f. Diagnosis or impression
g. Patient disposition
h. Immunization status (pediatrics & adolescents) as appropriate to the patient’s age & needs
i. Allergies
j. Growth charts (pediatrics) for Pediatrics Clinic and/or the Family Medicine Clinics whereby the facility serves as the source of primary care
k. Referrals, when necessary and/or appropriate
l. Communication to and from external practitioners or providers
m. Weight/length (pediatrics) as appropriate to the patient’s age & needs
n. Developmental status (pediatrics & adolescents) as appropriate to the patient’s age & needs
o. For those patients who are receiving continuing outpatient (ambulatory) services, a list of the following will be made upon initial presentation, if possible, however, no later than the third visit (third visit – when more complete information can be listed due to continuing care):
   1) Known significant medical diagnosis and conditions
   2) Significant operative and invasive procedures
   3) Adverse and allergic drug reactions
   4) Known long term medications (including current prescriptions, over-the-counter drugs and herbal preparations)
3. Emergency/Urgent/Immediate care records should contain the following:

   a. Time and Means of Arrival
   b. Pertinent history of the illness/injury and physical findings, including the patient's vital signs
   c. Emergency care provided to the patient prior to arrival
   d. Diagnostic and therapeutic orders
   e. Clinical observations, including the results of treatment
   f. Diagnostic impression
   g. Procedures performed
   h. Conclusion at the termination of treatment, including final disposition and follow-up care instructions.
   i. Whether the patient left against medical advice
   j. Notation that a copy of the record is available to the practitioner or medical organization providing follow-up care.

B. Chart Rules and Regulations

1. History and Physical Examination

   a. A complete history and physical examination shall be completed and filed on the patient's medical record within the first 24 hours of admission and prior to the performance of any surgery. A durable, legible original or reproduction of a medical history and a completed physical examination – obtained in the physician's office or through an oral and maxillofacial surgeon on the medical staff – that is completed or thoroughly updated within 30 days before admission is acceptable, if the patient’s condition did not significantly change during the period between documentation of the history and physical and admission to the hospital. In the case of 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. The history should include the following:

   1) Chief complaint
   2) Present illness
   3) Relevant past, family, and social histories, appropriate for age
   4) Inventory of body systems
   5) Evaluation of patient's developmental age (pediatric/adolescent records only)
   6) Consideration of education needs and daily activities (Pediatric/adolescent records only)
   7) Immunization status (Pediatric/adolescent records only)
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)

b. The physical examination should reflect a comprehensive current physical assessment. The recorded history and physical examination must be authenticated by a physician or when appropriate, by a qualified oral surgeon member of the medical staff.

c. 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, provided the original information is readily available.

2. History (Inpatient Pediatric & Adolescent) – up to age 18.

Refer to Section 1 for other assessment requirements

The history for all pediatric patients must include the following:

a. Psycho-social Assessment documented, objectively reporting the family history and current living situation and assesses family dynamics and their impact on the patient’s current needs, identifies those areas that may need to be addressed in treatment and evaluates family dynamics for discharge planning.

b. The medical history should include relevant past, social, and family histories appropriate to the patient’s age. A clinical assessment of each patient's needs, based on a social assessment is documented. Document social history of significance different from present.

c. Evaluation includes patient's developmental age as compared with chronological age. Document behavior or activities appropriate or inappropriate for chronological age, noting major areas of discrepancy, e.g., speech, gross motor, or fine motor.

d. Documentation of consideration of educational needs and daily activities. Play and other daily activities are relevant indices of children's and adolescents developmental level of functioning and psychological health. The need for a tutor or home bound instructions should be addressed.

e. Documentation of patient's immunization status. The hospital is responsible for requesting and recording information from the parents and/or guardians on the patient's immunization status. If the immunization status is unknown, this should be documented in the patient's medical record.
f. Documentation of evaluation of family's expectation for, and involvement in the assessment, treatment and continuous care of the patient. The medical record should document family and/or guardian contacts, both face to face and by telephone, with the patient and clinical staff. Document the parent's understanding of the prognosis and the anticipated length of stay.

g. Documentation of periodic review of the planned course of action, as appropriate. The treatment-planning process is completely individualized, based on current patient needs and clinical status. The treatment plan is updated when the patient's needs and response to treatment change. Document good daily progress notes with appropriate annotation of the parent's response to changes in the patient's progress.

h. Adolescent obstetric patients are assessed in the outpatient clinics during the initial obstetric assessment or at the time of admission to the hospital.

3. 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 document (at minimum):
   1) An evaluation note regarding the patient's overall condition and
   2) Information regarding the operative/procedure site

b. The history and physical must be completed within 30 days prior to the procedure unless an unstable medical condition exists. If the patient is medically unstable, the history and physical examination must be completed within 72 hours of the procedure.

c. 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, latex
   4) Existing co-morbid conditions, if any.

d. The extent to which the patient's physical status must be documented 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) Assessment of mental status; and
      b) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
2) Moderate Sedation:
   a) Assessment of mental status; and
   b) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
   c) Examination of heart and of lungs by auscultation.
   d) Allergies
   e) Family History of Anesthesia problems
   f) Medication History
   g) Abnormal lab results

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

5. Post Operative Documentation

Post operative documentation includes:
   a. Patient’s vital signs;
   b. Level of consciousness;
   c. Medications (including intravenous fluids), blood and blood components; any unusual events or post operative complications and management of such events;
   d. Name of providers of direct patient care nursing services or the names of people who supervised that care if it was provided by someone other than a qualified RN;
   e. Patient’s discharge from the Post sedation or post anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria;
   f. If discharge criteria are used, they are approved by the medical staff. Compliance with discharge criteria is documented, and
   g. If the patient is discharged by a licensed independent practitioner, the practitioner’s name is recorded in the post operative documentation.

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 and the result of treatment. An authenticated legible progress note is required daily to document medical necessity and acute level of care. All progress notes must be signed and dated.

7. Consultations

a. A request for a routine consultation shall be noted in the physician's orders. The consultation request form shall be completed and placed on the patient's medical record. The form should indicate the current date, time, reason for consultation, requesting physician's signature, printed name, and hospital service and beeper number. 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.

b. For outpatient consults, the physician shall submit consultations to the appropriate service.

c. Emergency or 'stat' consultations should be requested only when there is an emergency or urgent need for the consultation. The consultation form will remain on the chart. The physician will notify the Switchboard or 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 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 1) appropriate notes in the patient's medical record and 2) 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. All notes should show the date and time of the discussion.
9. Operative Reports

a. A legible comprehensive operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for use by any practitioner who is required to attend the patient. A complete operative report should also be dictated immediately after surgery and should include the following:

1) A description of the findings;
2) Procedures performed and a description of the procedure;
3) The specimens removed;
4) The postoperative diagnoses;
5) Names of the primary surgeon and any assistants;
6) Estimated blood loss

b. The surgeon must authenticate the completed operative report as soon as possible following surgery.

10. Pre and Post Anesthesia Evaluation

a. There must be a pre-anesthesia note in the patient's medical record prior to administering anesthesia that is reasonably expected to result in loss of protective reflexes. The note shall specifically include:

1) a history and physical exam,
2) any abnormal lab
3) anesthesia plan for the procedure
4) patient's previous drug history
5) other anesthetic experiences
6) any potential anesthetic problems

b. The medical records shall also reflect a post anesthesia visit.

11. Diagnostic and Therapeutic Orders (DNR, Verbal and Telephone Orders)

a. These orders include those legibly written by medical staff members, house officers and other practitioners within the scope of their professional practice.

b. “Do not Resuscitate” (DNR) orders must be countersigned by a faculty physician.

c. Verbal and telephone orders shall be accepted by the following healthcare professionals – registered nurses, registered pharmacists, licensed respiratory therapists, certified/registered EEG technologists and physical therapists. Verbal and telephone orders are tagged upon receipt by authorized staff when transcribing the order into the chart. The tag serves as a reminder
to the responsible physician that the order needs to be signed when he/she visits the floor. The physician shall countersign verbal and phone orders within 72 hours.

12. Transfers

When a patient is transferred within LSUHSC-S, from one level of care to another (for example, from hospital to residential care), and the caregivers change, a transfer summary may be substituted for the discharge summary (clinical resume’). A transfer summary briefly describes the patient’s condition at the time of transfer and the reason for the transfer. When caregivers remain the same, a progress note may suffice.

13. 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 Physician:
   5) Resident Physician:
   6) Referring Physician or Clinic:
   7) Admission Date:
   8) Discharge Date:
   9) Discharge Diagnosis (documented without the use of abbreviations)
   10) Reason for Hospitalization:
   11) Significant Findings (physical and laboratory):
   12) Hospital Course:
   13) Procedures Performed:
   14) 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.):
   15) Discharge Instruction (Diet, Activity, Medication, Follow-up):

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.

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.

14. Signature Stamps/Electronic Signatures

a. Rubber signature stamps are not authorized for use in the patient’s medical records. Printed legible stamps are acceptable to provide interpretation of illegible signatures.

b. The Sunquest Information System allows for the use of electronic signatures. The Department of Pathology utilizes this function to authenticate reports. Security of the electronic signature function is maintained by “linking” the electronic signature to the Sunquest password of the pathologist who is authorized to use it. Passwords are assigned only by the System’s Manager or the Assistant System’s Manager.

c. The Radiology Management System allows for the use of electronic signatures for Radiology Results. Security of the electronic signature function is maintained by “linking” the electronic signature to the Radiology Management System password of the Radiologist/Radiology Resident. The USER assigns passwords. (Radiologist/Radiology Resident) No one has access to their password and they are not known to anyone other than the user.

d. Electronic signatures/access to the Peritronics system is protected by password. Each user of the system has been given an individualized, secret password. Each person has a limited access code and the system is protected by access code level. System administrators are responsible for assigning access code levels, as deemed necessary and appropriate by medical staff and management.

e. The MUSE (Cardiology Information System) allows for the use of electronic signatures for Cardiology Results. Security of the electronic signature function is maintained by “linking” the electronic signature to the MUSE System password of the Cardiologist/Cardiology Resident. The USER assigns passwords. (Cardiologist/Cardiology Resident) No one has access to their password and they are not known to anyone other than the user.

f. SoftMed’s Electronic Signature Authentication (ESA) may be used to sign dictated medical record reports transcribed in the ChartScript application; these reports include discharge summaries, operative reports, history and physical exams, outpatient clinic notes, and some ancillary service reports.
Physicians are given individual passwords, editing access and training on ESA prior to activation; each physician is required to sign a confidentiality statement. The users are prompted to reset passwords every thirty (30) days and the passwords are known only to the user.

g. The Department of Emergency Medicine utilizes the Drs. Choice Program to allow for authenticated reports in the use of electronic signatures regarding patient charting. Security of the electronic signature function is maintained by linking the electronic signatures to the Drs. Choice Program password of the Emergency Medicine user who is authorized to use it. Passwords are assigned by the Business Manager or the Department Coder. Each person has a profile and the profile describes that user by ER Physician, Attending, Resident, PA, Nurse, Scribe, Other and Technician. Individual passwords are not known to anyone other than the user.

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

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