LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER  
- SHREVEPORT

ACCURACY AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

Purpose:

To define general guidelines for documentation of accurate, timely and complete medical records.

Policy:

1. A complete, legible and accurate paper and/or electronic medical record will be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient at LSU Health Sciences Center.

2. Medical record entries must be completed in a timely manner. Records not completed within 30 days of discharge are considered delinquent.

3. The following time frames shall be followed when documenting the patient's medical record:

<table>
<thead>
<tr>
<th>Table Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and Physical Examination</td>
<td>H &amp; P must be completed and documented within 24 hrs following admission of the patient but prior to surgery or a procedure requiring anesthesia. An H&amp;P performed within 30 days prior to admission may be used if the following requirements are met--the physician enters an update; indicates that the patient was examined; and notes no changes or documents changes that have occurred.</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>A daily progress note shall be entered into the electronic health record to provide a chronological record of the patient’s encounter.</td>
</tr>
<tr>
<td>Verbal Orders</td>
<td>Verbal Orders shall be minimized and authenticated within 5 days of the date authorized. It is not prohibited for physicians and other practitioners to text orders for patients.</td>
</tr>
</tbody>
</table>
Operative or other high-risk procedure report is entered into the electronic medical record or dictated upon completion of the operative or other high risk procedure before the patient is transferred to the next level of care. When the full report cannot be entered immediately a brief progress note is entered, including the following --names of the primary surgeon, any assistants, procedure performed and a description of each procedure finding, estimated blood loss, specimens removed and postoperative diagnosis.

Discharge Summary

A concise discharge summary shall be documented within 10 days post discharge, including the following - reason for hospitalization, procedures performed; the care, treatment, and services provided; the patient's condition and disposition at discharge; information provided to the patient and family and provisions for follow-up care. When a patient is seen for minor problems, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case and provisions for follow-up care.

4. The copy functionality in the electronic health record includes cut and paste, copy forward, cloning and any other intent to move documentation within or between records. This functionality can efficiently enter data and findings, however, inappropriate use may impact the accuracy of the data by adding unnecessary, irrelevant or inaccurate information to the record. The copy functionality must be used with caution.

Physician documentation must support medical necessity and the appropriateness of services provided. The copy functionality can assist in documentation if care is taken to edit records accurately to reflect the patient's condition at each encounter. In addition to protecting the integrity of the health record and the provision of quality care, this quality documentation reduces organizational risk and the risk of payer’s denials.

5. Abbreviations listed on the Prohibited Abbreviations List may not be used in the paper or electronic health record:

<table>
<thead>
<tr>
<th>Prohibited Abbreviations</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken as zero, four, or cc</td>
<td>Write unit</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td>Mistaken as IV or 10</td>
<td>Write international unit</td>
</tr>
<tr>
<td>QD, Q.D., qd, q.d., Q.O.D., QOD, q.o.d., qod (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an 'I' and the 'O' can be mistaken for 'l'</td>
<td>Write daily and every other day.</td>
</tr>
<tr>
<td>X.O - trailing zero . X mg - leading zero</td>
<td>Decimal point missing</td>
<td>Never write zero by itself after a decimal and always use a zero before a decimal point.</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td>----------------------------------------------------------------------------------</td>
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<tr>
<td>MS, MSO4 MgSO4</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write morphine sulfate or magnesium sulfate.</td>
</tr>
</tbody>
</table>

6. The electronic health record contains a summary list (snapshot) for each patient who receives continuing ambulatory care services.

7. A patient’s record is complete when the following criteria are met:
   - A medical history and physical examination
   - Admitting diagnosis
   - Results of all consultative evaluations
   - Documentation of complications
   - Properly executed informed consent forms
   - Practitioners’ orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports and vital signs and other information necessary to monitor the patient’s condition
   - Discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care
   - Final diagnosis

8. A weekly count of all incomplete and delinquent charts is generated by the electronic health record system on Sunday of each week. The report includes account of the number of total deficiencies, the total unique records, the total delinquent deficiencies and the total delinquent records. The report is distributed electronically to Hospital Administration, the Clinical Department Heads, Section Chiefs, residency coordinators and HIM management. Individual physicians receive notification electronically via their Pelican in-baskets of specific deficiencies requiring their attention.


10. Medical records entries shall be entered into the electronic health record at or near the time services are provided, except when the system is unavailable.

11. During downtime, the electronic health record downtime procedures shall be followed along with these record keeping practices:
   - All medical record entries must be legible, dated, timed and signed
   - Black or blue ink is recommended
   - Signatures shall include the first name, last name, licensure status and pager number.
• Errors shall be corrected by drawing a single, thin line through each line of incorrect information; dating and initialing the error and entering the corrected information in chronological order indicating which entry the correction is replacing.

Reference: Chancellor’s Memorandum 17
Medical Records Content Policy 6.5
Verbal Orders Policy 6.13.0

Administrator

10/18/12
Date

Approved by Clinical Board:  3/20/01, 5/18/04, 1/16/07, 1/19/10, 9/21/10, 10/16/12
Written:  10/94
Reviewed:  4/04, 12/06, 11/09, 8/10, 10/12
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