ARTICLE VI

MEDICAL RECORDS SERVICES

6.1 General Rules

A complete and accurate medical record shall be maintained for every individual who is assessed, cared for, treated or served.

(a) The purpose of the medical record is:

(1) To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment;

(2) To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the Hospital stay, during an ambulatory care or emergency visit to the Hospital, or while being followed in a Hospital- administered home care program;

(3) To document communication between the responsible practitioner and any other health professional contributing to the patient's care;

(4) To assist in protecting the legal interest of the patient, the Hospital, and the responsible practitioners; and

(5) To provide data for use in continuing education and in research.

(b) The medical record shall contain sufficient information to enable:

(1) The responsible practitioner to provide effective continuing care to the patient, to determine later what the patient's condition was at a specific time, and to review the diagnostic and therapeutic procedures performed and the patient's response to treatment;

(2) A consultant to render an opinion after an examination of the patient and a review of the medical record;

(3) Another practitioner to assume the care of the patient at any time; and

(4) The retrieval of pertinent information required for utilization review and quality review activities.

(c) All entries in the medical record are dated, signed, and timed.

(d) Only black ink will be used in any medical record documentation. The use of any other colored ink is not permitted.

(e) Weight must be documented in kilograms.

6.2 Contents

The medical record shall contain sufficient information to identify the patient, to support the diagnosis, to justify the treatment and document the results accurately.

(a) The medical record shall contain the following:

(1) Patient identification data; when not obtainable, the reason shall be entered in the record,

(2) The medical history of the patient, including the chief complaint, details of the present illness, and relevant past history;

(3) The report of a relevant physical examination,

(4) Diagnostic and therapeutic reports and orders,

(5) Evidence of appropriate informed consent; when consent is not obtainable, the reason shall be entered in the record,

(6) Clinical observations, including results of therapy,

(7) Reports of procedures, tests and their results,

(a) Preoperative diagnosis and operative reports, including a complete description of surgical procedure and findings;

(b) Pathology reports,

(c) Clinical laboratory examination reports,

(d) Radiology and nuclear medicine examination and treatment reports, and

(e) Anesthesia records

(8) Final diagnosis, condition on discharge and summary or discharge note and any discharge instructions; and

(9) Autopsy report, when performed.

(b) The attending Practitioner shall be designated upon admission. In the event the control of a patient's care is transferred in a written order to another Practitioner, the latter shall succeed as attending Practitioner. The order for transfer of care must be written or documented in the Practitioner's orders. Acknowledgement and acceptance must be documented by the accepting Practitioner.

(c) The attending Practitioner shall be responsible for preparing a complete medical record:

(1) A history and physical, including updates, must be recorded within twenty-four (24) hours after inpatient registration, except for surgical admissions where a history and physical must be recorded on the patient's medical record prior to the surgical procedure or a procedure requiring anesthesia. For procedures and surgeries performed by non-attending providers, a consultation or progress note which meets all content and time requirements may serve as the H&P for surgeries or procedures so as not to delay appropriate care. A compliant H&P is still required of the attending physician. For emergency surgical cases, document an admitting progress note stating the pertinent patient complaints, physical exam results, preoperative diagnosis, and the necessity for emergency surgery; and a complete history and physical is required within twenty-four (24) hours after the emergency surgery. Refer to Article V, Surgical Care.

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The history and physical shall include the following minimum requirements based on patient diagnosis and plan of care:

HISTORY:

(a) Admitting diagnosis;
(b) Chief complaint;
(c) History, present illness;
(d) Relevant past history;
(e) Current medications (can be found on the Home Medication ReconciliationReport);
(f) Allergies (can be found on Epic Allergy Navigator).

PHYSICAL EXAM:

(g) Vital Signs;
(h) Heart and Lungs;
(i) Impression/Plan of Care.
(j) These additional items may appear at the Practitioner's discretion, but are not required components of the history and physical:
    (1) Review of systems

(2) Relevant social and family history
(3) Occupational history
(4) Additional physical exam elements: Skin & General Assessment; Head & Neck; EENT – ears, eyes, nose, throat; Abdomen; Genitalia/Rectal; Pelvic; Extremities (pulses); Neurological assessment.

(k) The history and physical report must be dated and signed by the responsible Practitioner.

(2) If a complete history and physical has been obtained within one (1) to thirty (30) days prior to admission, such as in the office of a Medical Staff Appointee, a durable, legible copy of this report may be used in the patient's Hospital medical record, provided there is documentation on the history and physical at the time of admission that no subsequent changes have occurred, or the changes have been recorded. If a history and physical has been obtained within one (1) day of admission, an updated note (bridge note) is not required. If history and physical has been completed by a Non-Medical Staff Appointee, the history and physical may be used if updated to include reassessment, cosigned and dated by a Medical Staff Appointee upon admission.

(3) When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination (interval note) reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.

(4) An outpatient surgery procedure which requires a general anesthesia should have a full history and physical examination. An outpatient surgery procedure which requires a local anesthesia may have a brief history which contains the following information: chief complaint, pertinent and significant medical history, and a physical exam which includes a regional anatomical review associated with the procedure. An outpatient surgery which requires no anesthesia, i.e. YAG Laser procedures, shall have a history and physical exam as deemed necessary by the Practitioner.

(5) The following non-surgical invasive and other procedures must have documentation of history of present illness, pertinent past history, and pertinent physical examination on the patient's medical record prior to the procedure. This documentation is the responsibility of the patient's Practitioner but may be provided by any qualified Medical Staff Appointee. If history and physical has been completed by a non-Medical Staff Appointee, the history and physical must be updated, co-signed and dated by a Medical Staff Appointee upon admission. These high risk non-surgical

invasive and other procedures will be defined by the Medical Executive Committee and reviewed triennially.

Non-Surgical Invasive and Other Procedures:
Deep Organ Fine Needle Biopsy, Deep Core Needle Biopsy (i.e. Bone, Liver, Kidney, Lung, Pancreas), Arteriogram, Myelogram, Cardiac Catheterization, Angioplasty, Percutaneous Nephrostomy, Percutaneous Transhepatic Cholangiogram, Transesophageal Echocardiogram, Vena cavagram, Elective Cardioversion, Endoscopic Procedures and any procedures requiring Conscious Sedation, Bronchoscopy, Aortogram, and Discogram.

Scope of Assessment to Include:
Physical Exam which includes present illness, pertinent past history, pertinent physical exam including: Cardiovascular exam, Regional anatomic review associated with procedure. If procedure may require conscious sedation, include: General health status, Pregnancy testing, Anesthesia/ sedation history and complications, Airway assessment, and ASA score.

(6) Obstetrical records shall include all prenatal information. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable and shall be updated at the time of admission.

(7) Operative/invasive procedure reports and post operative procedure notes – Reference Article V – Surgery in the Medical Staff Rules and Regulations for contents and timeframes.

(8) Diagnostic tests interpreted by a credentialed Practitioner shall be documented in the medical record. Diagnostic reports must be interpreted within 24 hours of test/image availability and signed within 24 hours of transcription. Test images sent out for special studies/consultation will be considered unavailable until returned to the testing/imaging department.

(9) The discharge summary shall include the reason(s) for admission, final diagnosis, physical findings, treatment and operations, significant findings (test results), condition of patient on discharge, directions for subsequent care, instructions relating to physical activity, medication and diet and shall contain no symbols or abbreviations.

(a) All medications (including over the counter medications) to continue after discharge shall be listed on the order sheet.

(b) A final progress note may be substituted for the discharge summary in the case of patients who require less than a forty-eight (48) hour period of hospitalization (excluding behavioral health patients), and in the case of normal newborn infants. It documents the patient's condition at discharge, discharge instructions, and follow-up care required. The final progress note must be dated, timed and signed.

(c) In the event of death, a summation statement can take the place of the Expiration (Discharge) Summary or in the case of patients who expire less than a forty-eight (48) hour period of hospitalization. The summation note shall include the reason for admission, the findings and course in the hospital, the events leading to death and the final diagnosis.

(10) For orders, reference the section on Medical Orders in the Medical Staff Rules and Regulations.

(11) The progress notes shall give a pertinent chronological report of the patient's course in the Hospital. The clinical observations shall be made often enough to follow the course of the illness, including any change in condition and the results of treatment and therapy sufficient to permit continuity of care and transferability. Progress notes must be documented daily by either the attending, consulting or covering Practitioner. The attending Practitioner's employed/collaborating advanced practice nurse or physician assistant progress notes may meet the daily progress note documentation. Progress notes are to be signed, timed and dated.

Patients within the rehabilitation unit have physical medicine & rehabilitation rounding visits Monday through Friday and one weekend day with progress note documentation for each rounding visit.

(12) The consultation report shall contain a written opinion by the consultant that is signed, timed and dated and reflects, when appropriate, the actual examination of the patient and the patient's medical record(s).

(13) Medical records of donors and recipients of transplants shall include:

(a) When an organ or tissue is obtained from a living donor for transplantation purposes, the medical records of the donor and recipient shall fulfill the requirements for any surgical inpatient medical record.

(b) When a donor organ or tissue is obtained from a deceased patient, the medical record of the donor includes the date and time of death,

documentation by and identification of the physician who determined the death, and documentation of the removal of the organ or tissue.

(c) When a cadaveric organ or cadaveric tissue is removed for purposes of donation, the removal is documented in the donor's medical record.

(14) When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within two (2) working days and exchanged with the complete protocol within thirty (30) working days.

(15) Observation (Short Stay) Patients/Emergency Room Visits:

(a) Documentation of a history and physical exam report is required within twenty-four (24) hours of Observation/Emergency Room visit admission. The short form may be used; however, should the patient's status be converted to an inpatient, a complete and comprehensive history and physical exam report must be documented by the attending Practitioner.

(b) The final Practitioner progress note must include: patient condition at discharge, discharge instructions, and follow-up care required.

6.3 Incomplete Medical Records

The medical record must be complete of all deficiencies within thirty (30) days of patient's discharge. The Practitioner shall notify the Medical Records Department in advance of any date he/she will be out of town. All records in a Practitioner's incomplete medical record file must be completed before the date he/she is scheduled to be out of town.

If records become delinquent while a Practitioner is out of town, a seven (7) day grace period will be extended to that Practitioner. The grace period begins when the Practitioner returns.

6.4 Confidentiality of the Medical Records

All members of the Medical and Allied Health Professional Staff are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

Medical records shall be confidential, secure, current, authenticated, legible and complete.

The medical record is the property of the Hospital and is maintained for the benefit of the patient, the Medical Staff and the Hospital. It is the Hospital's responsibility to safeguard

both the record and its information content against loss, defacement, tampering and from use by unauthorized individuals.

(a) Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized to receive this information.

(b) Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

Quality of care must be reviewed and evaluated by peer groups in order to deliver optimal patient care; therefore, medical records may be issued to the Department Chair, Section Head and/or designee or an authorized representative of the Hospital for the purpose of review of quality of care as required by federal and state law. This review, if the original medical record is used, must be conducted within the confines of the Hospital. The Department Chair, Section Head and/or designee or authorized hospital representative shall be responsible for the confidentiality of contents and return of the medical records intact to authorized personnel of the Medical Records Department within twenty-four (24) hours after receipt of the medical records.

A Practitioner's access to patient records is limited to the necessary use for the treatment of patients or for participation in peer review activities. Upon written approval of the Institutional Review Board (IRB), access to the medical records of all patients shall be afforded to Medical Staff appointees for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the CEO or CEO designee, former Medical Staff appointees shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patients' medical records is forbidden without the written approval of the CEO or CEO designee.

6.5 Abbreviations

To avoid misinterpretation, only the abbreviations, signs and symbols listed in the Appendix to these Rules and Regulations shall be used in the medical record, excluding those abbreviations listed on the Unapproved Abbreviations list, also included in the Appendix.

6.6 Completing a Medical Record on an Unfamiliar Patient

No Medical Staff Appointee is permitted to complete a medical record on a patient unfamiliar to him in order to retire a record that was the responsibility of another Medical Staff Appointee who is deceased or unavailable permanently or protractedly for other reasons.

Adopted by the Medical Staff on 10/17/90
Approved by the Board of Trustees on 12/13/90
Revision to Section 6.2 approved by the Board of Trustees on 2/25/93
Addition of Section 6.7 approved by the Board of Trustees on 5/26/94
Revisions to Sections 6.2(c)(10) and 6.4(b) and addition of Section 6.2(c)(4) approved by the Board of Trustees on 10/18/96
Addition to Section 6.2(c)(9)-(a) approved by the Board of Trustees on 12/12/96.
Revision to Section 6.7 approved by the Board of Trustees on 7/23/98.
Addition of Section 6.8 approved by the Board of Trustees on 7/23/98.
Deletion of Section 6.7 approved by the Board of Trustees on 7/22/99.
Revisions to Sections 6.1, 6.2, 6.3, 6.4, 6.5, 6.6 adopted by Medical Staff 9/30/99
Approved by Board of Trustees on 10/28/99
Revisions to Section 6.2(c)(7)&(8) approved by MEC 5/2/00 and MRH Board 5/25/00
Revisions to Section 6.2(c)(2) & (15-b) approved by MEC 8/7/01 and MRH Board 8/23/01
Addition of Section 6.1(c) approved by MEC 10/2/01 and MRH Board 10/25/01
Revision of Sections 6.2(c)(2 & 5) approved by the MEC 5/7/02 and Board 9/26/02
Deletion of Section 6.2(c) (16) approved by MEC 9/3/02 and Board 9/26/02
Addition to Section 6.4 (HIPAA) approved by MEC 4/1/03 and Board of Trustees 4/24/03
Revisions to Article 6, Sections 6.1, 6.2, 6.3, 6.4, 6.5 recommended by MEC 9/6/05 and approved by Board 9/21/2005
Revisions to Section 6.2(c)(7) and 6.2(c)(9) recommended by MEC 5/2/06 and approved by MRH Board 5/17/06.
Revision to Section 6.5 recommended by MEC 1/9/07 and MRH Board 1/17/07.
Revisions to Sections 6.2(c)(1) & (11) recommended by MEC 9/4/07 and MRH Board 9/19/07.
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Revisions to Article 6, and deletion of Section 6.7 reviewed by Bylaws Cmte 10/20/10; MEC 1/4/11 approval by AMC Board 2/18/11.
Revision to Section 6.2(c)(1) Approved Bylaws Cmte 2/23/11; MEC 3/1/11; Board 3/16/11
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