Wake Forest University Baptist
MEDICAL CENTER

NORTH CAROLINA BAPTIST HOSPITAL

MEDICAL RECORD DEPARTMENT

HOUSE OFFICER

ORIENTATION – 2010

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North Carolina Baptist Hospital
Winston-Salem, North Carolina

Authentication Form
Electronic Signature, Computer Key Signature Acknowledgment

MEMORANDUM

TO: Attending Physicians, House Staff, and Other Providers

FROM: Jeanne Goode, Director - Medical Record Department

SUBJECT: **Authentication of Medical Records**

To meet regulatory standards on authentication of medical records entries:

Please sign on the line below as you will authenticate your medical record entries. If there are several ways you may authenticate (such as full name, initials only, first and last name only, etc), please include all of them on the signature line.

Some medical record entries may be authenticated with electronic signature or computer key signature. Your signature below also indicates you agree that: you will be the sole user of your electronic signature or computer key signature; you will not delegate the use of the electronic signature or computer key signature to any other user; and that you assume responsibility for any part of the medical record upon which the electronic signature or computer key signature is used.

Please enter the current date below and include your department in the space provided.

Please return this form to Jeanne Goode in the Medical Record Department.

Print Name:_____

_____
Signature (s)

_____ _____
Department Date

HOUSE STAFF ORIENTATION

MEDICAL RECORD DEPARTMENT

SECTION 1 - GENERAL POLICIES, SERVICES, AND INFORMATION

LOCATION: Fourth Floor, South Building

Staffed Hours:

File Area, Unit Number Control (Medical Record Numbers):
24 Hours/Day, 7 Days/Week
Retrieves medical records for patient care.

Doctors Workroom:
Monday - Friday, 8:00 am to 5:00 pm

Retrieves incomplete records for physicians to complete prior to scanning. Once the record is scanned, it is no longer available in paper form. If a physician wishes to complete records outside of staffed hours, arrangements must be made during staffed hours.

Transcription:
Monday - Friday, 8:00 am to 5:00 pm
Saturday - Sunday, 9:00 am - 1:00 pm
(See Section 5 for Stat Dictation)

Director: Jeanne Goode, RHIA

Assistant Directors: Gina Rose Everhart, RHIA
(Release of Med Info.;Files, Admin. Liason)

Pam Payne, RHIT
(Transcription, MR Completion, Professional Master, MR Review)

Kim Withers, RHIA
(Document Imaging, Unit Number Ctrl., Forms Cmt)

LOCATION**:** Downtown Health Plaza

Staffed Hours: Monday-Friday 8:00 am to 5:00 pm

Manager: Rosa Rodriguez, RHIA

EXTENSIONS**:** See Medical Center Directory under Medical Record Department

SECTION 1 - GENERAL POLICIES, SERVICES, AND INFORMATION, cont.

AUTHENTICATION OF MEDICAL RECORDS

The Medical Record Department maintains a provider authentication log. Physicians are requested to complete an authentication form and return it to Medical Records. Verification of handwritten signatures may be requested by insurance carriers. All documents transcribed by Medical Records such as H&Ps, Operative Reports, Discharge Summaries, and Clinic Notes are electronically authenticated.

FORMS COMMITTEE

It is the responsibility of the Forms Committee to approve forms, both paper as well as electronic formats for inclusion in the Medical Record. All original and revised forms as well as electronic templates created for inclusion in the medical record must be approved by this committee. For additional information, please access the Infinet at: http://intranet.wfubmc.edu/medrecords.

MEDICAL RECORD/UNIT NUMBERS

Each patient treated at the Medical Center is assigned a medical record number. Medical record numbers are controlled by the Medical Record Department. The Master Patient Index has over 2,044,930 patients. Medical record numbers may have 6 or 7 digits. The medical record number must be documented on all reports that are to be included in the medical record. Information needed for a medical record/unit number assignment is: full name of patient, address, maiden name (if appropriate), date of birth, race, sex, mother's first name, social security number (if appropriate.)

CONTENT OF MEDICAL RECORD

A single, lifetime medical record number is issued for each patient, and is used for inpatient hospitalizations, and for outpatient visits on the main campus, at the Downtown Health Plaza, CompRehab, and in the Wake Forest University Physician Practice (WFUP).

A medical record is maintained for every patient hospitalized, treated in the Emergency Department, the Hospital sponsored Outpatient Department Clinic, Ambulatory Surgery, Day Hospital. Records may be maintained in hardcopy and/or electronically.

Medical Records may be found in multiple locations:

> **Carecast, (Computerized Patient Record – Inpatient, Emergency Department, Day Hospital, Ambulatory Surgery, various outpatient care)**
>
> **Centricity, (Computerized Patient Record – Clinics: Wake Forest University Health Sciences, Hospital Outpatient Department, Downtown Health Plaza)**

SECTION 1 - GENERAL POLICIES, SERVICES, AND INFORMATION, cont.

NotesLink (Transcription and Authentication System)

Paper records filed in Medical Record Department

Paper records, filed in physicians' offices (Wake Forest University Physician Practice)

Downtown Health Plaza

CompRehab

OBTAINING A MEDICAL RECORD

Access to medical records of patients shall be afforded to members of the medical staff for study and research consistent with preserving the confidentiality of personal information concerning the individual patient. Researchers will be asked to provide IRB approval documentation, or to complete paperwork when chart review is preparatory to research. In case of re-admission of a patient, previous Hospital records shall be available for the use of the treating physician.

COMPUTERIZED AND IMAGED PATIENT RECORDS AND INFORMATION

Document Imaging System

The hospital has implemented a system for imaging of post discharge paper-based medical records. These images are viewable within Carecast (electronic medical record) under the tab "Scan Docs." The system was implemented on May 1, 2005 and currently holds images of medical records according to these general guidelines:

- Ambulatory Surgery Visits and Outpatient Endoscopy visits 5/1/05 forward.
- Advance Directives 1/2006 forward.
- Day Hospital, ECT, Outpatient Dialysis visits 2/1/06 forward
- GCRC visits 3/1/06 forward
- Emergency Department visits 6/1/06 forward
- Inpatient records from 10/1/06 forward. Records/Documents in Carecast and Centricity are not included.

Outpatient Department Clinic Imaging System:

Outpatient Department Clinic (OPD) and Downtown Health Plaza (DHP) paper documents are scanned after the patient's visit and viewable in the Centricity system.

A single patient may have records that are available electronically (on/after the implementation of document imaging), and records available in paper form only (prior to the implementation of document imaging).

For Patient Care: Scanned medical records may be accessed online. ***The goal is that medical records are scanned prior to their scheduled return for subsequent/follow-up care. When time does not permit scanning, paper-based records may be made available for patient care.*** Paper-based medical records (not yet scanned or any records for care prior to the implementation of scanning) are furnished for patients re-admitted to the Hospital, seen in the Outpatient Department, Emergency

Department, Day Hospital, or Ambulatory Surgery when needed. Records are provided to the Wake Forest University Physician clinics when requested. It is the responsibility of the clinic and secretary to request records 48 hours prior to scheduled appointments. Records for patient appointments are picked up on the day of the appointment and MUST BE RETURNED THE SAME DAY.*

For Research: The Medical Record Department retrieves paper-based records for research (see above). Statistical information to identify patients by diagnosis and operative procedure is available through Decision Support. Please discuss research requests with Information Services, Decision Support at extension 6-1970. Research is not handled on a stat basis. A five (5) workday notice is recommended.

For Review: If a paper-based record is needed by a House Officer for review only, it must be reviewed in the Medical Record Department. It is preferable for the House Officer to call the File Area at extension 6-3217 prior to coming to the Medical Record Department (main campus). To request a record to be pulled at the Downtown Health Plaza, call 3-9800 and follow menu instructions.

For Conference: Records needed for conference should be requested 48 hours in advance (2 working days.) 'Old' medical records (records which pre-date the implementation of document imaging) may be removed from the Medical Record Department on the day of the conference; but **MUST BE RETURNED THE SAME DAY**.*

> * Incomplete paper medical records may not be removed from the Medical Record Department except for patient care or completion of chart work by Faculty Physicians.

Other: Contact the Supervisor of the File Area.

Electronic: All typed reports are interfaced to downstream electronic systems immediately after transcription via the Noteslink application.

REMOVING MEDICAL RECORDS FROM THE MEDICAL RECORD DEPARTMENT OR HOSPITAL PREMISES

Original Hospital records are the property of the Hospital and removal from hospital premises is prohibited. If a subpoena or court order is received requesting removal, contact the Director or one of the Assistant Directors of Medical Records.

STATISTICAL INFORMATION

The Decision Support system contains statistical information (clinical and financial) on hospital patients. Statistical requests should be discussed with Information Services, Decision Support at 6.1970.

SECTION 1 - GENERAL POLICIES, SERVICES, AND INFORMATION, cont.

RELEASE OF PATIENT INFORMATION

The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) and North Carolina Statute recognize the confidentiality of medical information and confers a right on all patients to have their medical records treated as confidential and privileged. Individually identifiable information must be safeguarded in electronic or paper-based form.

Written consent of the patient is required for access or release of medical information to persons not otherwise authorized to receive the information.

The original paper medical record is owned by the Hospital and will not be released to anyone outside the Medical Center. Copies will always be made.

Electronic medical record systems are the property of the Medical Center. Access to protected information, use of handheld devices, and remote access is controlled via the Security Policy (PPB-MC-07).

The Medical Record Department is responsible for responding to any court order or subpoena for copies of the Hospital record. The Downtown Health Plaza Medical Record Department responds to subpoenas and court orders for records created or maintained at that facility.

Releasing WFUP office records is the responsibility of the physician's academic office or the WFUP Business Office. Requests received for WFUP records may be routed to Physicians' academic offices or the WFUP Business Office.

Patients may request copies of their medical record. Prior to releasing medical records to patients, families, or attorneys for patients admitted by the Department of Psychiatry, or seen in the Psychiatry OPD clinic, records will be reviewed by the Psychiatrist.

The Correspondence Section within the Medical Record Department is primarily responsible for releasing medical information for the Hospital. This section is available to answer further questions concerning release of medical information. The Downtown Health Plaza, Comp Rehab or other area maintaining departmental records not forwarded to the Hospital in either hard copy or electronic form may be responsible for releasing records created or maintained at those locations.

There are occasions when the Risk Management Department is requested to become involved in releasing medical information.

SIGNATURES

When handwriting signatures, **make legible and always include computer ID number**. **All entries must be signed, dated and timed.** Signatures on computer entries are electronic. Signatures on dictated/transcribed documents are all electronic.

SECTION 1 - GENERAL POLICIES, SERVICES, AND INFORMATION, cont.

COMMUNICABLE DISEASE REPORTING

A North Carolina Administrative Code requires all known or suspected patients with a communicable disease be reported to the Forsyth County Health Department. Physicians are encouraged to report a communicable disease as soon as they become aware of it.

CANCER REGISTRY

A Cancer Registry, approved by the American College of Surgeons, is maintained by North Carolina Baptist Hospital. The purpose of the Cancer Registry is to maintain surveillance over the course of each patient with a malignancy or selected benign neoplasms which include brain, central nervous system and salivary gland tumors. The primary functions of the Cancer Registry are the collection of relevant data, conduction of lifetime follow-up, and the dissemination of cancer information. The cancer data set includes patient demographics, cancer identification, and extent of disease (stage), treatment, recurrence, and outcome information. Documentation of the clinical TNM stage at initial workup and treatment planning is a quality assurance parameter along with the documentation of the pathological TNM stage after surgery. TNM staging is the responsibility of the managing/treating physician according to the American College of Surgeons' Commission on Cancer. The TNM staging documentation will be monitored by the Cancer Registry. The lack of staging information can affect the approval status. The Cancer Registry is available to assist physicians in research.

DEATH CERTIFICATES

At the time of death, the physician who pronounces the patient dead must immediately fill in and sign the certification portion of the death certificate. Under no circumstances are death certificates to be signed by students. Permanent black ink must be used in filling in and signing death certificates. In a medical examiner's case, the medical examiner is responsible for signing the death certificate. The Pathology Department is responsible for assuring death certificates are filled in and processed.

ERROR CORRECTIONS

When making a handwritten entry in the medical record, VERIFY patient's name on the chart. If an error is made:

- Draw one line through the incorrect information
- Write the date and time, and sign the entry.
- Do not try to obliterate the incorrect clinical information; a single strike-through is sufficient.
- For corrections to imaged documents, print a copy of the image, make the correction as described above and forward the document to the Medical Record Department - Attention Document Imaging. The document will be re-scanned into the medical record.

Corrections to transcription of dictated documents are made before you electronically authenticate. Electronic documentation systems such as the Menon System and Centricity require training provided through Information Services. Training includes procedures for error correction of electronic entries.

SECTION 2 - INPATIENT CHART DOCUMENTATION/COMPLETION REQUIREMENTS

ADMISSION HISTORY AND PHYSICAL

1. An admission history and physical must be completed and on the record within 24 hours of admission.

2. If a history and physical is dictated, an interim note must be handwritten on the record. The format elements for transcribed history and physicals are available on the MR Website (Infinet). The typed report is available in Carecast in four hours. You must log into NotesLink and electronically sign any dictated/transcribed report as soon as possible.

3. A Family Practice physician may be responsible for completing a history and physical on dental patients who are admitted for oral surgery when the surgeon is not privileged to perform the history and physical.

4. If a complete history and physical has been performed within 30 days prior to admission or outpatient/ambulatory surgery, such as in the office of a physician, a legible copy of this can be used to meet the history and physical requirement provided an update to the patient's condition since it was last assessed is documented in the medical record at the time of admission or the outpatient/ambulatory surgery. An update must be documented even if there has been no change.

   Note: Under no circumstances can a history and physical performed more than 30 days prior to admission or surgery be used even if updated. A NEW history and physical is required.

5. If a patient is re-admitted within 30 days for the same or a related problem, an interval history and physical may be documented in the inpatient record provided the original information is readily available and an update is documented. (see item # 4)

6. The attending physician may countersign the history and physical when completed by a House Officer.

7. If a history and physical has been dictated and typed, the attending physician may be asked to sign it even though there may be a handwritten H&P on the record signed by the attending. If available, the typed H&P is sent to the referring physicians or others requesting copies of the record; therefore, the physician is asked to sign it.

8. A history and physical (performed within 30 days) **and** updated must be on a patient's record prior to any surgery (see H&P format for Surgical Patients).

9. IF A PATIENT IS ADMITTED FROM DAY HOSPITAL OR AMBULATORY SURGERY, the history and physical must be updated and the reason for admission stated.

SECTION 2 - INPATIENT CHART DOCUMENTATION/COMPLETION REQUIREMENTS - *continued*

10. History and Physicals completed by medical students **do not meet** requirement that History and Physical be completed by licensed practitioner, even if countersigned by licensed practitioner.

PROGRESS NOTES

1. Progress notes may be written/entered by attending physicians, house officers, medical students, or designated nurse practitioners. Medical students' notes must be countersigned by a physician. All documentation (handwritten and electronic) must be signed by the author.

2. Progress notes must be dated, timed, and authenticated. Signatures must be legible and include physician computer ID number.

3. Progress notes shall be recorded as frequently as the patient's condition requires, but in any case at intervals of 72 hours (3 days) or less. If a patient has had surgery, a progress note is required for 5 consecutive days after surgery.

4. An electronic progress note form (Menon) is available on some services- separate training provided.

PROCEDURE NOTES

1. A procedure note is required to be written/entered in the progress notes for every procedure requiring patient consent.

2. For professional reimbursement for some patient financial types, such as Medicare, the attending physician is required to document his/her presence for the key portions of procedures performed and/or documented by a House Officer.

OPERATIVE REPORTS - see also Section 4 -- Incomplete Medical Records Policies - Transcription

1. Operative reports **MUST BE DICTATED IMMEDIATELY AFTER SURGERY**. Please refer to format for dictation in the Transcription Section of this handbook.

2. 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 progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes:
   - The name(s) of the primary surgeon(s) and his or her assistant(s)
   - Procedure performed
   - Description of each procedure finding
   - Estimated blood loss
   - Specimens removed
   - Postoperative diagnosis

SECTION 2 - INPATIENT CHART DOCUMENTATION/COMPLETION REQUIREMENTS - *continued*

This handwritten operative note must be written in the progress note section of the record immediately after surgery. Some services use an electronic document called "Brief Op Note" in Centricity to document the above items before transfer to the next level of care - PACU-; however this is not a substitute for an operative report and cannot be used as a complete operative report.

3. Operative reports must be signed electronically by the Dictator and Attending Surgeon.

4. In addition to the brief handwritten operative note in the progress note section of the chart, a **detailed operative note must be dictated immediately after surgery**. The Medical Record Department Transcription Area concurrently monitors compliance with this requirement.

5. Dictation services are available 24 hours per day. If the operative note has not been dictated the day of surgery, the attending surgeon is notified by e-mail. A list of missing operative notes is compiled and distributed to specified physicians and managers. If the operative note is not dictated within 24 hours, the attending surgeon's operating room scheduling privileges may be suspended until all outstanding notes are completed.

6. **PLEASE DICTATE AN OPERATIVE PROCEDURE ON THE DAY OF SURGERY.**

TRANSFER/ACCEPTANCE NOTE

1. An order should be entered in the medical record indicating to whom and when the patient is to be transferred.

2. If a patient is transferred from one clinical service to another while hospitalized, a transfer note must be written on the day of transfer by the service to which the patient is transferred.

3. The attending physician to whom the patient is transferred may write a note or countersign a note written by a house officer. For professional reimbursement, payers such as Medicare n may require attending co-signature on a transfer note.

DEATH NOTES

1. In the event of a death in the hospital, the deceased shall be pronounced dead by the attending physician or his designee.

2. The body shall not be removed from the floor until a full explanatory death note is written. "Fully explanatory" means a note which succinctly describes the circumstances of the death in such a way that the pathologist or other reviewer of the record can properly relate the final event to the preceding course.

SECTION 2 - INPATIENT CHART DOCUMENTATION/COMPLETION REQUIREMENTS - *continued*

PRE-ANESTHESIA NOTES

1. A pre-anesthesia evaluation must be documented in the record.

2. The pre-anesthesia note may be documented by a House Officer. A faculty anesthesiologist may be required to document a pre-anesthesia note for professional reimbursement.

ANESTHESIA RECORDS

1. An anesthesia record is required.

2. The faculty anesthesiologist must document involvement and authenticate the anesthesia record for some third party carriers such as Medicare.

POST-ANESTHESIA NOTES

1. A post-anesthesia note should be documented in the medical record.

2. A post-anesthesia note may be written/entered and signed by a House Officer.

3. For professional reimbursement for some patient financial types, such as Medicare, a post-anesthesia note by the faculty anesthesiologist may be required, including procedures done under local standby.

4. Post-anesthesia notes by Anesthesiology are not required for local anesthesia.

PHYSICIAN ORDERS

1. All orders written for a patient are to be accurately dated, timed, and signed. The order **must** also include signature, time, ID#, printed name, and beeper #. (ID# = your computer [Carecast] user number, which is same as your dictation number.) If error is made on handwritten medication order, use correction method as follows: Draw a horizontal line through incorrect information, date, time initial, and then clearly document the correct information.

2. Any telephone/verbal order must be signed by the responsible practitioner as soon as possible. Telephone/verbal orders are electronically authenticated in Carecast.

3. Only members of the service of an individual patient may write orders for the patient. Any orders written by consultants and other services must be countersigned. Exceptions are:

   - Medication ordered by members of the Anesthesia Department in the Post Anesthesia Care Unit or ICU, and for pre-anesthetic medication.

   - Preoperative orders written by members of the Radiology Department.

SECTION 2 - INPATIENT CHART DOCUMENTATION/COMPLETION REQUIREMENTS - *continued*

- Orders written by the service of the individual patient stating orders from another service may be accepted.

4. Computerized physician order entry (CPOE) is used in most inpatient patient care areas. Separate training to be provided.

CONSULTATION REPORTS

1. It is a policy of the Medical Staff to respond to all routine requests for consultations within 24 hours.

2. Consultation reports should be documented on the consult form.

3. The consult report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

3. If a consult report is completed by a house officer, the attending consultant must countersign the report, as appropriate, and indicate he/she has seen the patient and agrees with the documentation.

   Professional reimbursement may be affected if the consult is not signed by the attending physician.

DISCHARGE ORDER AND SUMMARY FORM – PAPER AND ELECTRONIC FORMAT

1. The Discharge Order and Summary Form must be completed before a patient is discharged. Please note this form is used as one method of communicating to referring physicians. (See attached Example 1) Please read the instructions carefully on the back of the form.

2. All diagnoses and procedures must be documented on the discharge form. These diagnoses and procedures are the basis for coding and grouping the patient into a DRG. The patient's DRG determines the Hospital's reimbursement on Medicare patients. These codes are also used for: submitting to insurance companies for non-Medicare reimbursement; for research and statistics.

   THESE DIAGNOSES AND PROCEDURES ARE ALSO SUBMITTED TO THE WAKE FOREST UNIVERSITY PHYSICIANS (WFUP) FOR USE IN ATTENDING PHYSICIANS PROFESSIONAL REIMBURSEMENT.

3. Referring Physician - At minimum, please give first and last name, street address, city and state.

4. The terminology used to document the final diagnoses and procedures on the discharge form must be consistent with the Standard Nomenclature of Diseases and Operations.

SECTION 2 - INPATIENT CHART DOCUMENTATION/COMPLETION REQUIREMENTS - *continued*

5. No abbreviations are acceptable when documenting the diagnoses and procedures on this form.

6. The discharge form must be completed and signed. Include physician ID number for identification.

7. If physician discharging the patient is not the same as physician responsible for dictating the discharge summary, please indicate responsible physician in designated block (below patient name label) or enter the name of "physician to dictate" in the Logician Discharge Document.

8. The electronic Discharge and Order Form (NCBH E-Discharge Document template in Centricity) is being used by some departments. This does not replace the DISCHARGE SUMMARY when completed for medications and instructions only. A Discharge Summary must be dictated (the Discharge Summary and Order form and text may be inserted into the discharge summary by the dictating provider when revising or signing to avoid duplication). The "RX" button in Noteslink inserts both the Medication List and E-Red Border Sheet.

   NOTE: Some services may use the "NCBH E-Discharge Document" as a discharge summary by entering the complete hospital course in addition to the diagnoses, procedures, disposition, instructions and other documentation. If the document is a full discharge summary; the author must route to the appropriate ATTENDING physician for countersignature - this does not flow automatically to attending physician.

DISCHARGE ORDER

1. Patients shall be discharged only on a written order.

2. The requirement for a written order may be met by filling in the Discharge Order and Summary Form.

DISCHARGE SUMMARY

1. A discharge summary must be dictated on all patients at the time of discharge or expiration. Formats for dictating Discharge Summaries are available on the MR Website - Infinet.

2. The attending physician at the time of discharge must countersign the summary by logging into Noteslink to electronically authenticate the document.

3. When a discharge summary is dictated, the dictator may confirm by signing physician ID number, initials or job number and date if using the paper discharge order and summary form in the space labeled summary dictated. (See Example 1 at back of handbook.)

Clinical Departments/Sections designate documentation responsibilities for attending physicians and house staff and this may differ by department.

HOUSE STAFF ORIENTATION

MEDICAL RECORD DEPARTMENT

SECTION 3 -AMBULATORY SURGERY, DAY HOSPITAL, OUTPATIENT CLINICS DOCUMENTATION REQUIREMENTS

AMBULATORY SURGERY

1. A history and physical examination is required on patients undergoing ambulatory surgery. *(See format for History and Physical Requirement for Surgical Patients located on MR Website).*

- If a complete history and physical has been performed within 30 days prior to admission or outpatient/ambulatory surgery, such as in the office of a physician, a legible copy of this can be used to meet the history and physical requirement **provided an update to the patient's condition since it was last assessed is documented in the medical record at the time of admission or the outpatient/ambulatory surgery. An update must be documented even if there has been no change.**

  Note: Under no circumstances can a history and physical performed more than 30 days prior to admission or surgery be used even if updated. A new history and physical is required.

- If a patient is admitted from Ambulatory Surgery, the History and physical must be updated to show the reason for admission and must meet inpatient History and physical requirements.

2. A handwritten operative note must be written on the record immediately after surgery.

3. An **OPERATIVE NOTE MUST BE DICTATED IMMEDIATELY AFTER SURGERY**. The format for operative notes is located on MR Website (Infinet) . The operative note must be signed by the surgeon.

4. Physician orders, pertinent events, and clinical observations are to be documented in the record.

5. Patient disposition and instructions given to the patient or family should be documented.

DAY HOSPITAL

1. An assessment is required on patients admitted to Day Hospital.

- If a history and physical has been obtained within 30 days prior to the admission, such as in the office of a physician, a legible copy of this report may be used, provided an update documenting changes is present.

- If a patient is admitted within 30 days for the same or a related problem, an interval history and physical may be documented in the patient's record provided the original is readily available.

- The history and physical must be signed by the dictator and may also be signed by the attending physician.

SECTION 3 -AMBULATORY SURGERY, DAY HOSPITAL, OUTPATIENT CLINICS DOCUMENTATION REGUIREMENTS, *continued*

- If a patient is admitted from Day Hospital, the history and physical must be updated to show the reason for the admission and must meet inpatient History and Physical requirements.

2. A procedure note must be documented for any procedure performed.

3. Physician orders, clinical observations, and pertinent events must be documented in the record.

4. Patient disposition and instructions given to the patient or family must be documented.

OUTPATIENT CLINIC DOCUMENTATION

Medical record documentation is required for every patient who is seen in the Outpatient Clinic.

The documentation must include the following:

- Patient identification
- Relevant history of the illness or injury and of physical findings
- Problem list
- Diagnostic and therapeutic orders
- Clinical observations including the results of treatment
- Reports of procedures and tests, and their results
- Diagnosis or impression
- Patient disposition and any instructions given to the patient and/or family for care
- Immunization status of children and adolescents and others as determined by law and/or hospital policy
- Growth charts for children and adolescents for whom the ambulatory care department/service is the source of primary care
- Allergies
- Referrals to practitioners or providers of service internal or external to the organization
- Communications to and from external practitioners or providers of service

Documentation must occur at the time of each clinic visit.

Forms used for Outpatient Clinic documentation are maintained in each of the clinics and may vary between clinics.

OPD Clinic Notes and Clinic Letters may be dictated by dialing 6-1777 (336-716-1777) from outside the hospital and entering worktype 15 (OPD Clinic note) or 14 (OPD Clinic Letter). Please see the dictation help card for more information on OPD Dictation. This card is provided to you during House Officer Orientation.

Medical Staff policies for completion of records are based on meeting JCAHO guidelines, Medicare requirements, licensure, and other regulatory/legal requirements.

HOUSE STAFF ORIENTATION

MEDICAL RECORD DEPARTMENT

SECTION 4 - INCOMPLETE MEDICAL RECORDS POLICIES

DOCTORS' WORKROOM

The Doctors' Workroom provides workstations for physicians who choose to complete chart work in the Medical Record Department. Once a record is scanned, it is no longer available in paper. Charts must be accessed and viewed through CareCast. Workstations are available throughout the hospital and through the WFUBMC portal.

The Doctors' Workroom is staffed as listed below. If physicians wish to complete records outside of staffed hours, arrangements must be made during staffed hours.

HOURS STAFFED: Monday - Friday, 8:00 AM to 5:00 PM

Incomplete records can be made available for physicians to complete in the Doctors' Workroom (prior to scanning) by special request.

CHART DEFICIENCIES

1. Medical Record deficiencies are determined by the quantitative audit of the medical record against specific regulatory requirements for complete documentation. If dictation is needed, an email notification is sent to the appropriate physician.

2. The bi-weekly *"Notification of Incomplete Records"* email provides detail of incomplete inpatient charts assigned. A snapshot of incomplete work (regardless of the discharge date) is compiled midweek (Wednesday evening) for e-mail notification on Thursday. It includes documents or telephone/verbal orders that need to be electronically authenticated and outstanding dictations needed.

3. Chart documentation responsibilities for House Officers and Attending Physicians are provided to us by the clinical departments/sections. The policies are not consistent across Medical Center. The Medical Record department assigns chart work according these department-specific guidelines.

4. If an incorrect assignment appears on the Notification **PLEASE INFORM THE THE DOCTORS' WORKROOM STAFF.**

   You may EMAIL us at "mailto:mradmin@wfubmc.edu" or call 6.6260.

HOUSE OFFICER NOTIFICATION OF INCOMPLETE RECORDS

1. Every other Thursday, House Officers receive an **e-mail memo** of incomplete records, regardless of discharge date. (See Example at back of handbook.) This e-mail is sent to a

SECTION 4 - INCOMPLETE MEDICAL RECORDS POLICIES, *cont.*

"WFUBMC" email account only. The email is identified as "Notification of Incomplete Records" with an attachment of deficiency details.

2. House Officers are responsible for completing their chartwork within 14 days from the date of their notification and for completing chart work on all available records, which may include records not listed on the notification memo. Most deficiencies (dictations and signatures.) can be completed remotely and will not require coming to the Medical Record Department. Electronic authentication in Carecast and NotesLink may be completed at any internal computer workstation or through the WFUBMC portal.

3. You may communicate any changes or problems with assigned chart work using the following link : mailto:mradmin@wfubmc.edu. This e-mail address is also listed in the WFUBMC e-mail contact addresses.

DELINQUENT POLICY - HOUSE OFFICERS

House Officers who fail to complete chartwork within 14 days from the date of their notification, are reported delinquent to their department Chairs and Chief Medical Officer.

Delinquent House Officers are subject to one of the following:

1. Being placed on vacation until records are completed. Vacation days consumed for this purpose will be subtracted from the total number of paid contractual vacation days provided the House Officer in the current year's contract.

2. If no vacation is available, being placed on suspension without pay, until such incomplete records are completed. Both pay and days-in-training will thereby be lost.

   The Department or Clinical Section is responsible for placing House Officers on vacation or suspension.

3. The Medical Record Department notifies the appropriate person, as defined by the Department or Clinical Section, when House Officers have completed their record responsibilities on all available records.

HOUSE STAFF ORIENTATION

MEDICAL RECORD DEPARTMENT

SECTION 5 - TRANSCRIPTION SERVICES AND FLOW OF TYPED REPORTS

For dictation formats and other dictation information - see separate listing on Medical Records Website

CORRECTIONS TO TYPED REPORTS:

1. All documents are transcribed as dictated. The transcriptionists do not edit the dictation.

2. Corrections and revisions should be made in the NotesLink application during the authentication process. If a correction must be made after authentication, legibly make the correction and return to the transcription department.

COPIES OF TYPED REPORTS:

Copies of transcribed reports are distributed via the MedPort delivery system. Documents are readily available in Carecast (Computerized Patient Record) for viewing and/or printing as needed.

ROUTING OF TRANSCRIBED REPORTS:

Admission History and Physicals - *Electronic authentication in Noteslink*

After transcription, documents are available electronically in the signature queue of the dictator. Once the dictator reviews and electronically approves the document, it flows to the signature queue of the admitting (teaching) physician.

Documents should be reviewed and approved daily so they may be available to the admitting attending for timely co-signature.

Operative Reports - *Electronic authentication in Noteslink*

After transcription, documents are available electronically in the signature queue of the dictator. Once the dictator reviews and electronically approves the document, it flows to the signature queue of the Attending Surgeon.

Documents should be reviewed and approved daily so they may be available to the surgeon for timely co-signature.

Discharge Summaries - *Electronic authentication in Noteslink*

After transcription, documents are available electronically in the signature queue of the dictator. Once the dictator reviews and electronically approves the document, it flows to the signature queue of the Attending Physician.

Documents should be reviewed and approved daily so they may be available to the attending physician for timely co- signature,

SECTION 5 - TRANSCRIPTION SERVICES AND FLOW OF TYPED REPORTS, *cont.*

Letters - *Electronic authentication:*

Letters are not sent to the addressee prior to signature; it is very important that they are signed timely.

After transcription, documents are available in the signature queue of the dictator.

OPD Clinic Notes/Letters - *Electronic authentication:*

After transcription, documents are available electronically in the signature queue of the dictator. Clinic notes requiring countersignature by the supervising physician flow to the supervising attending when indicated (based on the clinic/attending).

HOUSE STAFF ORIENTATION

MEDICAL RECORD DEPARTMENT

SECTION 6 - REFERRING PHYSICIAN COMMUNICATIONS

The Medical Record Department facilitates referring physician communication. At the time of registration, "referring and family physician" designations are made by **the patient** and entered into the Hospital registration system (Healthquest/Patient Management). The referring physician and/or family physician appear on the registration form, which is available in the patient's medical record. Reports are transmitted to these physicians according to departmental guidelines.

DISCHARGE ORDER AND SUMMARY FORM

A copy of the Discharge Order and Summary Form is routed to a patient's referring physician(s) the day after discharge. If using a paper form, insert the referring physician's name and address in the designated entry box. Specifying the referring physician(s) on this form will help the Medical Center assure patient continuity of care. The electronic Discharge Document is routed to the referring physician but **only after it is signed in Centricity.**

EMERGENCY DEPARTMENT

Emergency Department documentation can be routed to referring physicians by specifically identifying the recipient in the document text.

OUTPATIENT CLINIC - HOSPITAL SPONSORED

Physicians may dictate letters to referring physicians using the Hospital's dictation line (6.1777).

To send a Clinic Visit to referring physicians, a clinic letter (work type 14) must be dictated. Always state the referring physician as the addressee.

INPATIENTS - DISCHARGE SUMMARIES AND HISTORY AND PHYSICALS

Discharge summaries and history and physicals are routed to referring physicians based on the guidelines of each Department/Section. In order to assure copies are routed appropriately, the dictator must include the name of the referring physician and any known address in the dictation. If this information is not included, copies may not be routed as desired. Referring physician information is available on the patient registration forms or attachments to the registration form.

Some documents may be sent to referring physicians before authentication to expedite communications. Referring physicians receive copies of subsequent revisions.

Referring physicians receive documents electronically or by the postal system.

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SECTION 7

"EXHIBITS"

#1: Discharge Order and Summary Form - *PAPER* - (Red Border Sheet – page 1)

#2: Notification of Incomplete Records

#3: List of Prohibited Abbreviations

EXHIBIT 1: Discharge Order and Summary Form (Red Border Sheet) page 1

Phasing Out – To Become Electronic

NORTH CAROLINA BAPTIST HOSPITAL
WINSTON-SALEM, NC 27157

DISCHARGE ORDER and SUMMARY

PHYSICIAN TO FILL IN ALL **BLACK** AREAS
NURSE TO FILL IN ALL RED AREAS

DO NOT USE MEDICAL ABBREVIATIONS OR SYMBOLS
PLEASE PRINT

ADMIT DATE	DISCHARGE DATE	REFERRING PHYSICIAN
REFERRING PHYSICIAN ADDRESS	ATTENDING PHYSICIAN AT DISCHARGE	PROVIDER TO DICTATE DISCHARGE SUMMARY, IF APPLICABLE

ADMITTING DIAGNOSIS

DISCHARGE DIAGNOSIS

SECONDARY DIAGNOSES/COMPLICATIONS/CO-MORBIDITIES

PROCEDURES DURING THIS HOSPITALIZATION	DATE

DISPOSITION SELECT ONE
- ☐ Home
- ☐ Home with Home Health Svc
- ☐ Another Hospital
- ☐ NCBH Acute Bed
- ☐ Skilled Nursing Facility
- ☐ Rehabilitation Facility
- ☐ NCBH Rehab Unit
- ☐ Long Term Acute Care Hosp
- ☐ Assisted Living

See Definitions on Back
- ☐ Expired
- ☐ Against Medical Advice
- ☐ Intermediate Care Facility
- ☐ Hospice in the Home
- ☐ Hospice in Medical Facility
- ☐ Miscellaneous Facility
- ☐ Psychiatric Facility
- ☐ NCBH Psych Unit
- ☐ To Correctional Facility
- ☐ Swing Bed

☐ **See CMSW Notes for Details**

DATE OF ONSET OF PRESENT ILLNESS	ESTIMATED DATE OF TERMINATION OF DISABILITY

SUMMARY DICTATED
DATE _____ BY _____

INVASIVE LINES / DEVICES ☐ YES ☐ NO

HOME CARE INSTRUCTIONS

MEDICATIONS

LISTED BELOW ARE YOUR DISCHARGE MEDICATIONS	Times to Take Daily	Continue as Before	Prescription Given	Information Given	LISTED BELOW ARE YOUR DISCHARGE MEDICATIONS	Times to Take Daily	Continue as Before	Prescription Given	Information Given

Do Not Use.

Use Medical Reconciliation Process.

☐ NO MEDICATIONS NEEDED AT DISCHARGE

DIET: Your Diet Is: _____

ACTIVITY: ☐ No Restrictions ☐ Resume Same Activity ☐ Up with Crutches or Walker, Weight Bearing as Instructed ☐ Complete Bedrest
☐ DO NOT: ☐ Bend ☐ Stoop ☐ Lift ☐ Drive ☐ Move Furniture ☐ Do Strenuous Activity ☐ Climb Stairs
☐ Up as Tolerated ☐ OTHER: _____

FOLLOW-UP: ☐ No Appointment Necessary ☐ Return Appointment in _____ Wks. to Dr. _____ ☐ Card to be Mailed ☐ Call Home Doctor for Appointment

DISCHARGE PATIENT: _____ ORDERING PHYSICIAN'S SIGNATURE _____ DATE / TIME _____ DISCHARGE NURSE'S SIGNATURE _____ DATE

SPECIFIC DISCHARGE CARE INSTRUCTIONS (Nurse and/or Physician) - Dressings, Incision Care, Equipment, Instructional Materials

DATE	NURSE/PHYSICIAN SIGNATURE	INSTRUCTIONS
		Signs/Symptoms to Call Your Doctor:

Smoking Cessation Advice: TOBACCO Use and Second hand smoke are hazardous to your health. If you or anyone in your household smokes, you/they should STOP. For tips on quitting and other resources, refer to the pamphlet Smoking and Tobacco Cessation Advice.

I have been told and understand these HOME CARE INSTRUCTIONS:

SIGNATURE OF PATIENT / FAMILY REPRESENTATIVE _____ DATE _____

09-007200 (8/05)

DISORD

EXHIBIT 2: Notification of Incomplete Records

This is how your notification will appear in your email. You must open the attachment to see the detail of your incomplete charts.

From: Medical Records Notification [mradmin@wfubmc.edu] Sent: Thu 6/7/2007 7:10 AM

To: Pamela Payne

Cc:

Subject: Confidential - Notification of Incomplete Records

Attachments: rpt.htm (22 KB)

Attached is your bi-weekly Notification of Incomplete Records.

Please contact us by email at mailto:mradmin@wfubmc.edu if there are any errors or questions about your chartwork.

Alternatively, you may call the Doctor's Workroom at 716-6260 or 716-3225.

EXHIBIT 3: Prohibited Abbreviations

Prohibited Abbreviations

Note: This listing replaces the "Unacceptable Abbreviation List."

Note: 100% compliance expected per JCAHO. See below for further explanations.

Abbreviation	*Potential Problem*	*Preferred Term*
U, u	**Mistaken as zero, four or cc**	**Write "unit"**
IU	**Mistaken as IV or 10**	**Write "international unit"**
QD, Q.D., qd, q.d. QOD, Q.O.D., q.o.d., qod	**Mistaken for each other. The period after the "Q" can be mistaken for an "I", and the "O" can be mistaken for "I".**	**Write "daily" and "every other day".**
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	**Decimal point is missed.**	**Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)**
MS MSO_4 $MgSO_4$	**Confused for one another. Can mean morphine sulfate or magnesium sulfate.**	**Write "morphine sulfate" or "magnesium sulfate".**
µg	**Mistaken for mg, resulting in 1000-fold overdose**	**Write "mcg"**
AS, AD, AU (for ears) OS, OD, OU (for eyes)	**Mistaken for each other**	**Write "left ear", "left eye", etc**
X3d, etc	**Interpreted as 3 doses instead of days**	**Write out "doses" or "days"**

Information relating to this standard is found in the Joint Commission 2010 Comprehensive Accreditation Manual IM.02.02.01:

- **The hospital uses uniform data sets to standardize data collection throughout the hospital.**
- **The hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.**
- **The hospital follows its list of prohibited abbreviations, acronyms, symbols, and dose designations.**
- **A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.**
- **The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.**

For questions regarding medication orders, please contact:
Kathy Bricker, PharmD, BCPS, Pharmacy Drug Information at 6-9780

For questions regarding other forms of medical record documentation, handwritten, preprinted or computerized, please contact:
Kim Withers, RHIA, Forms Committee Chairperson at 6-0821.