HSHS St. Francis Hospital

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FACILITY: HSHS St. Francis Hospital	**MANUAL(S): Medical Staff Policy Manual**
TITLE: Definition of Complete Medical Record Documentation	**ORIGINATING DEPARTMENT: Administration**
SUPERCEDES: MS-13-01, Dated March 2013	**POLICY NUMBER: April 2016**

I. POLICY:
The HSHS St. Francis Hospital Medical Staff will follow current regulatory requirements in completing medical record documentation.

II. PURPOSE:
To provide guidelines for complete medical record documentation.

III. DEFINITIONS:
- Complete: within the time standard as approved by the medical staff
- Time-sensitive emergency: Case where any delay in surgery or treatment has the potential for imminent loss of life, limb, or eyesight.
- H+P: History and physical exam.
- Delinquent: Completed after the time that has been established as a standard for completion.

IV. GUIDELINES/PROCEDURES:
The following identifies the portions of the medical record and required documentation:

A. Admission History and Physicals

1. Will include the relevant chief complaint, history of present illness, past medical history, allergies, current medications, surgical history, family history, review of systems, physical examination, provisional diagnosis and plan of care.

2. Will be considered complete if documented electronically or on paper by the admitting or attending physician within 24 hours of admission.

3. Will be considered delinquent if NOT completed by the admitting or attending physician within 24 hours of admission.

4. Will be considered delinquent, but complete if completed more than 24 hours after admission.

B. Pre-Surgical History and Physical

1. Will include the relevant chief complaint, history of present illness, past medical history, allergies, current medications, surgical history, family history, review of systems, physical examination, diagnosis and plan of care.

2. Will be considered complete if:
   a. Completed on the day of the procedure, but BEFORE the patient enters the operating room by the surgeon or attending physician.

   b. Completed by the operating or attending physician within 30 days prior to the procedure AND accompanied by a H+P addendum completed by a physician on the day of the surgery, but BEFORE the patient enters the operating room.

3. Will be considered complete if:
   a. Completed on the day of the procedure, but BEFORE the patient enters the operating room by the surgeon or attending physician.

   b. Completed by the operating or attending physician within 30 days prior to the procedure AND accompanied by a H+P addendum completed by a physician on the day of the surgery, but BEFORE the patient enters the operating room.

4. Will be considered incomplete if it does not meet the above requirements. Patients will not be brought into the OR with incomplete H+P's

5. In the setting of a time-sensitive emergency, a Pre-Surgical H+P be considered complete when it is completed within 24 hours after the procedure.

C. Operative Reports

1. Will include summary of intra-operative events.

2. Will be considered complete if completed within 24 hours after surgery.

3. Will be considered delinquent if not completed within 24 hours after surgery.

4. Will be considered delinquent, but complete if completed more than 24 hours after surgery.

D. Discharge and Death Summaries

1. Will include a summary of the events of a patient's admission and hospital course.

2. Will be considered complete if completed within 15 business days of the patient's discharge (or death) from the hospital.

3. Will be considered delinquent if NOT completed within 15 business days of the patient's discharge (or death) from the hospital.

4. Will be considered delinquent, but completed if completed more than 15 business days after the patient's discharge (or death) from the hospital.

E. Written Orders

1. Will be considered valid if written by a physician or authorized nurse and dated, timed, and signed before the physician leaves the area.

F. Telephone and Verbal Orders

1. Will be considered complete if written by the nursing staff and dated, timed, and signed (or e-signed) by a physician within 72 hours of the date of the original order.

2. Will be considered delinquent if NOT dated, timed and signed (or e-signed) by a physician within 72 hours of the date of the original order.

G. Progress Note

1. Will be considered complete if it documents:
   a. findings that would justify continued hospitalization
   b. significant alteration in the patient's condition
   c. any change or anticipated change in the course of treatment

2. Is necessary when a patient's condition changes or a new treatment plan is implemented.

H. "Do Not Use" Abbreviations:
Medical Staff members will refrain from using "do not use" abbreviations specified by the hospital.

V. REFERENCES:
The Joint Commission
CMS Regulations
Hospital Licensing Act, Rules and Regulations, Section 250.1510