

	<b>Cooper Green Mercy Health Services</b>	<b>POLICIES &amp; PROCEDURES: ADMINISTRATIVE</b>		
	<b>APPROVED:</b> 	<b>ISSUED:</b> 3/16		<b>PAGE:</b> Page 1 of 3
<b>SUBJECT:</b> <b>Medical Record Content</b>		<b>REVISED:</b>		<b>REVIEWED:</b>

## I. BACKGROUND:

The patient record is legal documentation of every individual who has been treated or received medical or health care services at Cooper Green Mercy Health Services. It contains the patient name, age, identifying information, reason for the visit or service, the diagnosis including all supportive information for that diagnosis, and all data that is obtained during the visit. It is a continuous document in that all clinical encounters with an individual are maintained in a single distinct uniquely identifiable medical record. Information that is stored in the medical record must follow all state and federal regulations.

The medical record, whether written or electronic, is health information that is protected by HIPAA's privacy regulations. As a result, any unauthorized disclosure of the medical record is protected by federal regulation and punishable by fine and by imprisonment.

The medical record policies clarify what information is required to be entered into the medical record, to whom permission is granted to enter information into the medical record, how that information must be presented, how errors are corrected, retention requirements, and charges for duplicating the record.

The current medical record is electronic developed by Medsphere and Stockell as defined in the Medical Records Usage Policy and Procedure and is the current official medical record of Cooper Green Mercy Health Services. Prior to May 1, 2012, the hard copy of the medical record, in conjunction with selected portions of the electronic health record created in Meditech served as the official medical record. The record is maintained according to law by the Custodian of Records in Health Information Management.

## II. PURPOSE

To accurately document the patient's health history and each distinct encounter of a clinical nature with providers and staff of Cooper Green Mercy Health Services.

## III. POLICY

It is the policy at Cooper Green Mercy Health Services to maintain a quality medical record which is carefully documented, complete, accurate, legible, relevant, timely, secure and informative.

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#### IV. DEFINITIONS

- A. Provider includes physicians, certified registered nurse practitioners or physician assistants.
- B. Encounter includes all face to face visits, telephone conversations regarding clinical issues, such as providing results or diagnostic tests, any other interaction between a provider and/or staff and a patient that affects the clinical treatment of a patient.

#### V. PROCEDURE

- A. Every patient is to have their own unique medical record with demographic information and date of service for each encounter.
- B. Documentation in the medical record is required to include the following information:
  - 1) To be obtained, completed and entered into the EHR by the nurse or PCT and reviewed/validated by provider:
    - (a) Chief complaint
    - (b) Vital signs (including height, weight, pain scale)
    - (c) Significant past medical history
    - (d) Current medications
    - (e) Where available past medications
    - (f) Immunization status
    - (g) Family and social history
    - (h) Allergies
    - (i) Signature of staff
  - 2) To be completed and entered into the EHR by the provider or through transcription and signed by the provider:
    - (a) Physical examination
    - (b) Procedures/treatments
    - (c) Diagnosis
    - (d) General Impression notes
    - (e) Provider Level of Care
    - (f) Signatures of provider
    - (g) Written and signed orders for procedures, tests, and medications (specifying dose and route).

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- (h) Diagnosis codes related to each order for ancillary services such as laboratory or imaging in a clearly linked manner.
- C. All entries into the medical record should be sufficient to satisfy the information needs of any third-party administrator or third-party payer.
- D. Charts are to be legible and will be available and accessible for future review.
- E. All reports of procedures, tests and their results are documented and authenticated in the medical records.
- F. Ancillary diagnostic reports are resulted and may be shared with the patient by the physician/medical care provider. The patient is given opportunity to ask questions, assuring full understanding of results. All abnormal results are documented as such in the medical record. Any abnormal or critical diagnostic reports received after the patient is gone from the facility will be forwarded to the physician both through electronic notification requiring a provider's electronic signature upon review, and telephonic notification for review and follow up with the patient.
- G. The area from which the abnormal or critical report was generated will electronically document the time, date and recipient of telephonic contact. The physician/medical care provider will document the follow up encounter with the patient.
- H. Each encounter in the medical record will have a provider or staff signature as appropriate and noted above.
- I. Discharge instructions are given to every patient upon leaving the facility. The instructions are to include the discharge diagnosis, prescriptions, procedures or treatments to be continued at home, referral physician for further follow up and emergency instructions.
- J. Any pharmaceutical prescriptions or other clinical orders as a result of an encounter with a provider will be documented in the appropriate section of the EHR.
  - 1) Orders for ancillary and support services will be completed using the appropriate order template in the EHR, signed and a notification, whether electronically automatic or manually generated in the EHR will be created, signed and sent to the appropriate person or location.
  - 2) Pharmaceutical prescriptions must be entered and signed in the template of the EHR. Printed prescriptions must be generated through the EHR. Hand written prescriptions are not acceptable, except in an emergency or computer down time and as soon as possible entered into the EHR.
  - 3) E-prescribing will be completed as appropriate following state and federal guidelines.