# POLICY & PROCEDURE

| TITLE: Medical Record Completion (eClinicalWorks) | | | | |
|---|---|---|---|---|
| **Scope/Purpose:** To ensure timeliness in the completion of documentation for a patient encounter in order to protect integrity of the electronic legal health record | | | | |
| **Division/Department**: All HealthPoint Clinics | | **Policy/Procedure #:** | | |
| **Original Date: November 27, 2013** | | **_X__New ___Replacement for:** | | |
| **Date Reviewed:** | **Date Revised:** | **Implementation:** | **CPIC Approved:** | **Board Approved:** |
| | 02/05/14 | 07/02/14 | 07/02/14 | |
| **Responsible Party: Director of Compliance/QA; Director of EHR System Development** | | | | |

DEFINITIONS:

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| Completion | The process of *completing an entry* in the health record by which documentation related to the visit is completed by the provider. The signature is applied and the entry is considered complete. An entry is complete when the DONE button is clicked. |
| Locked | The process by which health record entry is deemed complete. Once "locked" any changes to the entry must be made through an amendment. Records will be electronically "signed" by the provider/staff when closed. Once locked the billing processes can be applied. |
| Required Entry | A completed medical record shall include the entry of the following (at minimum): chief complaint, history of present illness (HPI), current meds, past medical history, allergies, vital signs, exam, assessment, treatment consistent with chief complaint, visit code and follow/up. |

POLICY:

Medical records must be locked within 72 hours of client visit. Failure to complete records within specified timeframes may result in disciplinary action as defined in the Medical Record Delinquency Policy and Procedure.

Prompt documentation of a medical encounter ensures

- the provider or nurse remembers the encounter accurately
- up-to-date advice by the health care team, especially if the patient, pharmacist or other health care professional calls for clarification of a visit decision
- timely billing

PROCEDURE

## I. Timely completion

All health records will be complete and locked within 72 hours by individuals responsible for that encounter and/or who are permitted to document in the medical record.

A. For every patient visit with provider, the problem list, medication list, medication allergy list, and any future appointments must be documented and/or updated before the patient checks out in order for client to receive his/her clinical visit summary. This is achieved by:
    1. Clinical visit summary is printed with each visit
    2. Client is enrolled and information is available through Client Portal
B. If the provider is going on vacation or will not be in the office for an extended period of time all records must be signed before leaving on that time off.
C. Telephone encounters should be completed by the end of the same business day but no later than 48 hours.
    1. More than one staff person will be able to add to the note as the issue evolves over time.
    2. If the patient call is not resolved within 48 hours due to the inability to reach the patient (patient will not return calls, bad phone number, etc.) this information should be documented in the note, then closed and signed. A new note can be started if the patient calls back after that time.
        i. For abnormal results, per provider's orders, a clinical staff member will attempt to contact the patient/parent/guardian.
        ii. If telephone contact is unsuccessful after at least three attempts, or disconnected phone number, then a written letter will be sent in accordance to the Test Tracking Procedure.
        iii. This information must be documented in the note.
D. Non-urgent laboratory items need to be reviewed and managed within 24 hours of the results being received.
E. Critical laboratory results are reported by the laboratory to the provider.
    1. The lab company will call the individual provider's clinic during normal office hours for critical lab results.
    2. After normal hours, the lab company will reach the provider through contact information on record for after hour calls.
    3. Providers on vacation: Other providers or nurses will be assigned to vacationing provider jelly beans to view for critical labs or diagnostic results while the provider is away.
F. If a patient is seen for a nurse only visit (example: injection, immunization, dressing change, etc), it is documented in the progress note and locked.
G. Verbal telephone orders are countersigned by the prescriber within 24 hours.
H. Immunizations are documented in a progress note and the immunization record is updated automatically from this documentation. Historical immunizations can be added during a regular visit through the immunization link or through a telephone encounter and by directly updating the immunization record.

## II. Entries in the Medical Record

A. Who Can Record Entries
   1. Entries in the medical record shall be made only by members of the professional staff, nursing staff, allied health professionals and HealthPoint employees as authorized by HealthPoint and professional staff rules.
   2. Medical record entries shall be made only by personnel directly involved in treatment or observation of the patient, and recorded at or about the time of treatment or observation.
   3. Health care personnel currently licensed, registered, or certified may accept and record verbal orders related to their licensure or scope of practice. This includes orders for Laboratory and other ancillary services.
      The following health care personnel currently licensed, registered, or certified in the State of Texas shall be authorized to accept verbal or telephone orders for medications within their scope of practice.
         - Registered Nurse **(RN)**
         - Licensed Vocational Nurse **(LVN)**– excluding **blood products, total and peripheral parenteral nutrition**, intravenous **medications**, and investigational medications
         - Registered Pharmacists **(RPh)**

B. Recording Entries in the Medical Records
   1. All entries in the medical record automatically identify the date and time of the entry. The date and time will identify when the entry is made, regardless of whether it relates to prior events.
   2. All entries in the medical record shall be factual; irrelevant information and humor should be avoided in recording entries. If opinions are entered into the medical record, they shall be clearly identified as such by leading the notation with "in my opinion…".

C. Abbreviations and Symbols
   1. Abbreviations and symbols may be used in recording entries in the medical record when approved by the Compliance and Performance Improvement Committee and the Board.
   2. A list of approved medical record abbreviations and symbols shall be maintained in the Medical Records Department.

D. Errors and Corrections
   1. Errors in the medical record shall be corrected by creating an addendum and noting the error.
   2. All corrections shall be time stamped with staff/provider name and date.

E. Verbal Orders (refer to Verbal Orders Policy & Procedure)

F. Signatures – Authentication
   1. All documentation in the Electronic Health Record (EHR) progress notes or telephone encounters will be electronically signed by the HealthPoint employee responsible for locking the note when the encounter is complete.
   2. No HealthPoint employee shall authenticate an entry for another person. The parts of the medical record that are the responsibility of the medical practitioner are to be authenticated by him/her.

3. It is also acceptable for a covering physician to sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. All orders, including verbal orders, must be dated, timed and authenticated promptly by the prescribing practitioner or another practitioner responsible for the care of the patient, even if the order did not originate with him/her.
4. The Covering Physician is a physician of the same specialty as the attending or consulting physician who assumes responsibility for the care of the patient within a specific time frame.

## III. Monitoring

A. Completion of charts will be monitored every two weeks by appropriate designee (Compliance and Quality Assurance Department, or other assigned person).
B. Report of unlocked records (delinquencies) will be communicated via email to clinic managers, providers, Chief Medical Officer, Administrator of HealthPoint Initiatives and Director Compliance/QA.
C. Compliance reports will be presented to Compliance and Performance Improvement Committee (CPIC), Professional Review Committee, and the Board.

## IV. Incomplete Medical Records and Delinquencies

A. The medical record shall be completed within 72 hours after the patient visit
B. A provider should only complete a medical record on a patient that is familiar to him in order to retire a record of another staff member.
C. The Chief Medical Officer or designee may retire the medical record as "incomplete" only if the physician is deceased, has moved from the area, has resigned from the medical staff, or is on an extended leave of absence. In this situation the following statement will be added to the record:

   "incomplete: Due to the departure/death/or permanent incapacitation of the health care provider the _____report is unavailable and this record is being filed incomplete by order of the Chief Medical Officer_____"
   Sign/Date_____

D. Delinquent Medical Records are managed in accordance to the Employee Handbook Policy for Disciplinary Action. Compliance to the policy will be considered in evaluations and/or privileging processes including professional peer review. Providers will not be granted annual leave or CME days if records are not completed.

RELATED POLICY:

Locking Progress Note Procedure
HealthPoint Policy – Disciplinary Action
Critical Value Policy & Procedure

REFERENCES:

22 TAC 165.1 TMB requires contemporaneous record completion for licensed physicians; Medicaid requires it to support billing

Standard – within 24 hours or 5 days if there is an unusual interruption (unexpected leave, etc.)

Texas Medical Liability Trust—electronic records locked within 24-48 hours "Risk Management Guide for Physician Practices" (2005 revised 2010)

Amendments, Corrections, and Deletions in the Electronic Health Record: an American Health Information Management Association Toolkit (2009)
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678

Update: Maintaining a Legally Sound Health Record—Paper and Electronic
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDocName=bok1_028509

REQUIRED BY:

Meaningful Use

ATTACHMENTS/ENCLOSURES:

Approved Abbreviation List

**POLICY/PROCEDURE TRACKING FORM**

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| **Date of Revision** | **Description of Changes** |
|---|---|
| 02/05/14 | Added disciplinary component |
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