HSHS St. Vincent
St. Mary's
St. Nicholas
St. Clare

COPIES ARE ONLY VALID ON THE DAY PRINTED

FACILITY:	HSHS St. Vincent Hospital HSHS St. Mary's Hospital HSHS St. Nicholas Hospital HSHS St. Clare Memorial Hospital HSHS St. Clare Rural Healthcare Clinic HSHS Libertas Treatment Center	**MANUAL:** Record of Care Treatment and Services
TITLE:	**Medical Record - Regulations**	**ORIGINATING DEPARTMENT:** HIM
SUPERSEDES:	SVGB 100-08-005 SMGB A-2091 SNS HA-Me.6 SCO QMSSD105	**POLICY NUMBER:** MR-009

I. POLICY:

The medical record reflects standards of documentation, organization, format and confidentiality.

II. PURPOSE:

To reflect the plan of patient care.

To furnish documentary evidence of the course of the patient's hospital stay or visit.

To serve as a communication tool for health care personnel involved in the patient's care.

To protect the legal interests of the patient, practitioners, and hospital.

To provide data for use in continuing education and research.

To clarify documentation requirements for acute care hospitals, critical access hospitals, rural health clinics, hospital department clinics and behavioral healthcare facilities.

III. DEFINITION:

The term "Medical Staff Member" (MSM) used throughout this document as a general reference includes any physician, dentist, podiatrist, and/or psychologist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.

The term "Advanced Practice Clinician" (APC) used throughout this document as a general reference as defined in the *Advanced Practice Clinician Credentialing* Policy.

The term 'Hospital Department Clinic' includes: HSHS St. Clare Rural Healthcare Clinics, SCO Regional Surgery Center, St Gianna Clinic, Pediatric Hematology Oncology, Medical Oncology, Radiation Oncology, Genetics, Cystic Fibrosis Clinic, Sleep Disorders Center, and Women and Infants.

Table of Contents

I. ORGANIZATION

1.1. A unit record system is used for maintaining medical records on patients for whom services have been provided (i.e., outpatient, inpatient, and emergency department (ED) admissions on one patient are filed under one medical record number.) Documentation is entered by authorized providers into an electronic health record (EHR) system and made available to authorized users within Hospital Sisters Health System (HSHS) Eastern Wisconsin Division (EWD) hospitals, Prevea Health and authorized Affiliates. The documented information is owned by the Hospital.

1.2. Paper medical record forms are used when there is no means to electronically document the information. The forms are approved by Forms Committee. Completed forms are scanned into the patient's EHR.

1.3. Reports received from other facilities that are applicable to the care of the patient are scanned into the EHR.

1.4. Reports of telemedicine services provided are scanned into the patient's EHR. Telemedicine includes the provision of healthcare services from a distance using audio, video and computer technology.

II. LEGAL ASPECTS

2.1 Ownership of the Record
- a. Original medical records are the property of the hospital. Original records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order or as approved by the Chief Operating Officer or designee.

2.2 Release of Information
- a. Written informed consent of the patient or his/her legal representative is required for release of medical information to persons not otherwise authorized to receive this information.
- b. Medical record policies governing release of information and retention of medical records are defined by hospital or HSHS policies.

2.3 Physician and APC Access to Medical Records
- a. Any Physician and APC involved in the care of a patient may have access to the medical record, including prior records of the patient. Medical students, interns, residents, pre-med and physician assistant students may have access to patient medical records in which they have been directed or supervised by their sponsoring MSM; or received permission from the attending MSM in cases where they have not been involved in the care of the patient.
- b. Request for access to patient records or abstracted patient information for research must be submitted in writing to the hospital's Research Committee or Institutional Review Board (IRB) for consideration and approval.
- c. Access to medical records for peer review and quality monitoring are defined through the Medical Staff departments/clinical services/committees, *Medical Staff Peer Review* policy (MS-011) and the use of defined objective review criteria.

2.4 Access to view/document in the EHR is based on the provider's job title/role and security settings.

2.5 Consent
- a. Consents
  1. The hospital shall obtain a signed consent for treatment according to hospital policy.
  2. Consent forms signed by/for a patient receiving care or treatment becomes a part of the medical record.
- b. Special Consent Forms
  1. Special consents are obtained as defined in the divisional *Informed Consent* policy (MR-003). For Libertas refer to *Patient Client Rights* policy no. 008.

2.6 Record Retention
- a. The medical record is maintained at least ten (10) years in legally acceptable medium. See HSHS *Record Retention* policy (RC-07).

III. DOCUMENTATION - CLINIC RECORDS

Hospital Department Clinics' are exempt from all other sections of this policy unless specifically indicated.

3.1 Content
- a. Sufficient and accurate patient identification information (See 4.2).
- b. Pertinent history of the injury or illness, chief complaint, physical findings, vital signs.
- c. Problem list.
- d. Allergies.
- e. Medications.
- f. Evidence of consent forms, as applicable.
- g. Office note documented per office visit.
- h. Diagnostic and therapeutic orders.
- i. Reports of physical examinations, procedures, tests and results, consultative findings.
- j. Instructions given to the patient and/or family regarding necessary follow-up care, treatment and services.
- k. Other pertinent information necessary to monitor the patient's progress.

IV. DOCUMENTATION-GENERAL REQUIREMENTS

4.1 Authentication
- a. Entries in medical records are made only by individuals given this right as specified by contract, in the *Medical Staff Bylaws, Rules & Regulations*, in hospital policies or on their individual privilege card or scope of practice card.
- b. Entries shall be accurately written/entered and represent the care/ services provided. Handwritten entries must use blue or black ink.
- c. Entries are authenticated as follows:
  1. MSM - by recognizable signature, initials, or electronic signature.
  2. APC, medical students, residents, interns, physician assistant students & hospital employees - name and title, or electronic signature.
  3. Nursing staff - first initial, family name and title or electronic signature.
  4. The practitioner signature authenticates the content of the document and places responsibility for the content on the signing practitioner. Signatures where a practitioner added a disclaimer noting the signing practitioner is not responsible for the content either due to possible errors in transcription or Dragon or other speech recognition application interpretations are not appropriate. When disclaimers are found in signed documents the document will be referred back to the practitioner and considered incomplete until the disclaimer is removed and the document signed. A note advising that speech recognition was used and to contact the author if any questions with the content is acceptable.
- d. Medical record entries are legible, dated and timed. Issues with legibility are addressed with the individual.
- e. Electronic signatures from outside facilities systems are accepted.
- f. Where other documentation systems are developed/purchased that utilize electronic signature for medical record documents, the system for applying electronic signature must comply with electronic signature regulations.

4.2 The medical record contains information unique to the patient, which is used for patient identification, including but not limited to patient name, date of birth, medical record number.

4.3 Abbreviations
- a. Abbreviations and symbols may be used in the medical record if they are listed within the web-based version of Neil Davis' Medical Abbreviations. See HSHS policy on *Abbreviation Use* (MR-08). Exception: No abbreviations may be used in the final diagnosis including when listed on the discharge summary or on the informed consent for surgery document.
- b. Unacceptable Abbreviations (Do Not Use List) may not be used anywhere in the record. These abbreviations have been identified through current literature as having the potential to cause harm to patients.
- c. The web-based version of Neil Davis' Medical Abbreviations and the Do Not Use List are available on the hospital's intranet site.

4.4 Transcribed Reports
Dates and time of dictation and transcription are indicated on transcribed reports.

4.5 Reports created within the EHR document the date and time the note was created.

4.6 Reports from Outside Facilities
Reports received for the medical record from outside facilities must be clearly labeled as to source and must contain sufficient information to identify the patient. The recipient is responsible to verify each document is labeled.

4.7 Original or Acceptable Copy
The original or an acceptable copy of documents containing clinical information pertaining to a patient's stay is scanned to the medical record.

4.8 Error Correction
a. If an error is made in paper documentation in the medical record, draw a single line through the improper notation, mark "error" above it, initial it, date and time it.
b. If the document requiring correction is a paper document that has been scanned into the EHR, the author requests Health Information Management (HIM) staff print the document in error. The author hand-writes the correction and the document is scanned to the patient's record. The original document is deleted from the EHR.
c. If the document requiring correction is a transcribed report, the author may utilize 4.8.b. as indicated above or may dictate an addendum.
d. For corrections in the EHR, consult the Epic Chart Correction Guidelines located on the Epic Learning Dashboard under Resource Links.

4.9 Late entries
a. When the electronic chart is accessible for editing, enter the date/time the documentation should have been noted. The actual date/time of the entry is automatically recorded. If the late entry is a narrative note, identify it as 'Late entry'. For medications given at a time other than as scheduled, the system requires a reason to be entered.
b. Once the electronic chart is no longer accessible for editing, the HIM manager/designee should be made aware of any late entries. The chart can only be accessed on designated PC's. The process for creating the late entry is as noted in 4.9.a.
c. Late entries should not be made more than two days after the date of service without manager/supervisor approval.

4.10 Delinquent Medical Records
a. The desired time-frame for completion of the medical record is at the time of the patient's discharge (inpatient or outpatient) from the hospital.
b. A medical record is considered delinquent when it has not been completed within fourteen (14) days after the patient's discharge.
EXCEPTION: A medical record is considered delinquent when a History and Physical (H&P) is not documented within twenty-four (24) hours of admission or prior to surgery, whichever comes first, the operative report is not documented within 24 hours following surgery and/or verbal orders are not signed within 48 hours. The chart is delinquent only for the MSM(s) or APC(s) responsible for documentation of the missing H&P, or operative report or unsigned verbal orders.
c. The HIM Department shall relay information to the Chief Physician Executive or designee(s) concerning MSMs/APCs with delinquent records that merit relinquishment of privileges. The MSMs and APCs shall be notified of the existence of delinquent records via email, phone calls, fax or communication with support staff. Delinquent records that are not completed seven (7) days after the MSM/APC has been notified will result in automatic relinquishment of admitting privileges for MSMs or automatic relinquishment of privileges or scope of practice for MSMs/APCs who do not have admitting privileges.
d. The MSMs whose admitting privileges have been automatically relinquished shall not be allowed to admit patients to the hospital (including making room reservations), to schedule elective surgery, or be scheduled to administer anesthesia, to provide service or care to a patient admitted under another MSM, to provide consultation, or to treat non-emergency patients in the ED. True emergency cases and call coverages are an exception, but these cases may be subject to retrospective review. APCs whose

privileges or scope of practice have been automatically relinquished shall not be allowed to provide service or care to inpatients, outpatients or ED patients. True emergency cases are an exception, but these cases may be subject to retrospective review.

e. A MSM's admitting privileges or an APC's privileges/scope of practice will not be automatically relinquished if sick or on vacation when the notification is received, and he/she does not return until after the due date. If the MSM or APC has received less than three (3) days' notice before leaving for vacation, a grace period is granted which extends seven (7) days from the date of return. This grace period does not apply to MSMs whose admitting privileges or APCs whose privileges/scope of practice were automatically relinquished prior to their illness or vacation and after they have received the letter notifying them of their delinquent records and due date. Exceptions are granted by HIM leadership on a limited basis.
f. MSMs serving on a temporary (Locum Tenens) basis are responsible to check Epic In Basket for incomplete records. Incomplete documentation may be noted after the provider leaves scheduled service.
g. If a MSMs admitting privileges or an APCs privileges/scope of practice have been automatically relinquished for two (2) weeks in a row or two (2) times in a rolling calendar year, he/she will meet with an HIM leader to address the recurring issue of incomplete records. If relinquishment of privileges occurs within the next six (6) months, the MSM/APC will meet with the Medical Staff leader and an HIM leader.
h. Should the MSM or APC fail to complete delinquent charts within three (3) days of relinquishing privileges, an Executive Letter will be sent. If records are not completed by the date specified in the Executive Letter, the MSM/APC is considered to have voluntarily resigned from the Medical Staff. If this letter from the Chief of Staff (designee of the Executive Committee) is received three (3) times in a rolling calendar year, the MSM/APC shall be considered to have voluntarily relinquished his/her medical staff privileges and to have resigned from the medical staff. Relinquishing of privileges will occur when the third letter is received. The HIM Director/designee works with Medical Staff Services to send the relinquishment notice to the appropriate hospital colleagues.
i. The procedures for enforcing the automatic relinquishment and notifying hospital personnel when the MSM/APC's privileges or scope of practice are to be reinstated are determined by the hospital.

4.11 Retiring of Incomplete Medical Records

a. No MSM/APC is permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another MSM/APC who is deceased or unavailable for other reasons.
b. If possible, the MSM/APC is contacted to complete the chart. If he/she cannot be contacted or is unavailable to complete the chart, then a notice is filed by the HIM Department on the chart stating it is being filed incomplete due to the unavailability of the MSM/APC. See *Electronic & Handwritten Signatures* policy (MR-03).

4.12 Medication Reconciliation

a. Medication reconciliation is completed on each patient on admission, upon transfer of level of care to the next provider of service, and when discharged home. In settings where medications are used minimally (ED, outpatient radiology, ambulatory care, short stay services, clinics) or prescribed for a short duration, modified medication reconciliation processes are performed.
b. See *Medication Management and Reconciliation* policy (PH-015).

V. DOCUMENTATION-OUTPATIENT RECORDS

5.1 Emergency Department Records (excludes Libertas)

a. An ED record is created for every patient who registers for ED care. The record shall contain:
    1. Sufficient patient identification information.
    2. An accurate recording of arrival time and means and/or by who transported.
    3. Pertinent history of the injury or illness, physical findings, vital signs.
    4. Allergies.
    5. Medications.
    6. Documentation of emergency care provided prior to the patient's arrival at the hospital.
    7. Diagnostic and therapeutic orders.
    8. Clinical observations and care and treatment provided in the ED.
    9. Documentation of the administration of procedural sedation.
    10. Reports of procedures, tests, and results.

11. Diagnostic impression.
12. Final disposition and a precise statement of the condition of the patient on discharge or transfer.
13. Instructions given to the patient and/or family regarding necessary follow-up care.
14. Documentation of patient's leaving against medical advice (AMA).

b. The provider (MSM or APC) responsible for initiating, supervising and/or rendering care and treatment in the ED shall sign the ED record.
c. The SANE (Sexual Assault Nurse Examiner) report is signed by the Nurse Examiner and co-signed by the physician responsible for the patient's care and treatment in the ED.
d. The ED records are documented STAT in those cases where the patient is admitted as an inpatient, if the patient is referred for follow-up within five (5) days, or where the patient is covered by Worker's Compensation.
e. Each MSM or APC, who examines the patient in the ED, is required to document his/her findings.
f. For documentation guidelines/requirements when scribes are utilized, see policy - *Use of Scribe to Document in the Medical Record for a Medical Staff Member* (MS-027).
g. Residents, interns and provider students may document ED notes as outlined in hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).

5.2 Outpatient Records

a. Patients seen on an outpatient basis shall have a record of the care provided to them.
b. Information required for the record may vary with the type of outpatient visit, but should include basic patient identification information.
c. Clinical data including results of diagnostic tests and treatment appropriate to the patient's referral for treatment are included in the record and authenticated by the responsible party.
d. Outpatient visits require documentation of why the patient is having treatment/tests provided to them with an appropriate order.

5.3 One-Day Care Records (excludes Libertas)

a. Short Stay Service Records, Interventional Radiology, GI, Cardiac Cath Lab Records
    1. The minimum components of the Short Stay Service medical record shall include:
        a) Nursing Assessment.
        b) MSM/APCs' orders.
        c) Discharge Instruction Record.
        d) Consent for Treatment.
        e) Documentation of care rendered to the patient.
    2. Surgical patients' medical records shall also include the following:
        a) Informed consent for the procedure to be performed.
        b) Recovery room record.*****
        c) Pre- and Post-Operative orders.
        d) H&P ***** - see section 6.1.
        e) Operative/procedure report - see section 6.3.d.
        f) Laboratory reports when appropriate.
        g) Operating room record.*****
        h) Anesthesia record.*****
        i) Peri-Operative record.
        j) Pre-and post-anesthesia note ***** - see section 6.3.b.
        k) Pre-Op checklist.
        l) Written instructions given to the patient and/or family regarding necessary follow-up care.

        ***** Applicable for patients undergoing general, regional, or monitored anesthesia care
b. Observation Outpatients (discharged within 48 hours of admission to a bed); Extended Outpatient Recovery (excludes Libertas)
    1. Definition
        a) Observation - a time period to evaluate an outpatient's condition or to determine the need for a possible inpatient admission.
        b) Extended Outpatient Recovery - a time period of routine recovery from a procedure beyond the time Short Stay Services is open.
    2. Documentation
        a) Patient identification.

b) ~~MSM and AHP~~ Physician or APC order and reason for ~~admission to~~ Observation Outpatient or Extended Outpatient recovery status.
c) Progress notes regarding the patient's condition and disposition.
d) Results of diagnostic tests and treatments appropriate to the patient's admission to observation outpatient.
e) H&P, if necessary - see section 6.1.
f) Operative report/procedure note, if procedure performed.
g) Anesthesia documentation, if anesthesia administered.
h) Nursing documentation.
i) MSM discharge order.
j) Written instructions given to the patient and/or family regarding necessary follow-up care.

5.4 Outpatient History and Physical Examinations - see section 6.1. (excludes Libertas)

5.5 Outpatient Orders - see section 6.5.b.

5.6 Outpatient Assessment (Libertas only)
a. Chemical use: All patients served in the outpatient programs will be assessed by a certified counselor to assess their chemical use as to frequency, amount and duration. The assessment will also include a review of diagnostic symptoms (source: current Diagnostic and Statistical Manual of Mental Disorders).
b. Psych-Social Assessment: All patients are asked to provide psychosocial information to include family, employment, religious/spiritual beliefs, legal history, financial history, medical history, educational and vocational experience.
c. Medical: Each patient will answer a medical physical/mental evaluation given by their counselor. The evaluation will address past and current medical/physical status, including a pain review. The evaluation will address the patient's orientation and mental status. If the counselor or the patient requires or requests a more complete evaluation, referral is made to a RN or primary care physician.
d. Psychiatric: Patients who have a history of psychiatric problems are expected to continue their prescribed treatment with their mental health professional.
e. Vocational: The patient's vocational/military/school experience/environment and impact of alcohol/drug use.
f. Family: Family history will be collected for information and alcohol/drug use in the immediate or extended family.
g. Spiritual: Patients beliefs/practices and those of family.

VI. DOCUMENTATION - INPATIENT RECORDS

6.1 History & Physical Examination (See also Appendix B of *Medical Staff Bylaws*)
a. H&P Performed After Admission/Registration:
1. Inpatients; and outpatients with anesthesia (excludes Libertas): An H&P examination must be documented in the medical record within twenty-four (24) hours after admission/arrival at the hospital or prior to surgery (whichever comes first).
2. The H&P is documented in the EHR by a MSM or APC who has been granted privileges by the Hospital to perform histories and physicals.
b. H&P Performed Prior to Admission/Registration (excludes Libertas):
1. An H&P performed more than thirty (30) days prior to an admission/registration is invalid.
2. An H&P completed no more than thirty (30) days prior to inpatient admission or outpatient procedure requiring anesthesia (outpatients with anesthesia) may be incorporated into the medical record under the following conditions:
a) The previous H&P is in the medical record. If completed in a provider's office by a Nurse Practitioner (NP) or Physician Assistant (PA), the H&P will be accepted by the hospital with the signature of the NP or PA.
b) The MSM or APC with approved privileges that include performing and documenting H&P updates examines the patient and completes an H&P update to document any changes to the previous H&P or to note there are no changes.
c) The H&P update must be documented no later than twenty-four (24) hours after admission, or in the case of surgical patients, prior to surgery or a procedure involving anesthesia, whichever

comes first. The H&P update must be dated, timed and authenticated or countersigned by the MSM.

c. H&P Requirements for Procedural Sedation (referred to as Pre-Sedation Assessment) - see *Sedation Policy* (D-26). (excludes Libertas)

d. Emergency Situations - In case of an emergency where there is no time to perform and document the H&P prior to surgery or a procedure involving anesthesia due to the patient's condition, it will be completed as soon as possible after surgery. (excludes Libertas)

e. Newborn (excludes Libertas)
H&P must be documented in the EHR by the newborn's attending physician or APC with approved privileges (see 6.1.l.d) for content) within 24 hours of birth. The delivering MSM or nurse midwife with the staff nurse assesses infant stability at birth. The delivering provider will call for a consult (i.e. by a neonatologist or neonatal nurse practitioner) when newborn stabilization is required.

f. Oral Surgery/Dental Records (excludes Libertas)
   1. A patient admitted by a dentist shall require two H&P examinations: A medical H&P examination performed and signed by a physician and a dental history and examination performed by the dentist. **Exception**: For any patient who is normal and healthy (ASA 1 equivalent) or who has mild systemic disease with no functional limitations (ASA 2 equivalent), dentists and oral and maxillofacial surgeons may perform a complete admission H&P examination and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so and have been granted privileges by the Credentials Committee and Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with a patient.
   2. For any patient with severe systemic disease (ASA 3 equivalent) or with severe systemic disease that is a constant threat to life (ASA 4 equivalent), a medical H&P examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental or oral surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
   3. The dentist or oral and maxillofacial surgeon shall be responsible for the oral surgery care of the patient, including the appropriate H&P examination, as well as all other appropriate elements of the patient's record.
   4. A legible copy of the dental history and complete exam performed in the office within thirty (30) days prior to admission may be incorporated into the medical record if authenticated by the examining dentist or oral/maxillofacial surgeon with an interval note (H&P update) indicating the patient was examined prior to surgery or a procedure involving anesthesia. Any additions, changes, "no change", etc. based on the interval exam are to be documented. This notation must be dated, timed and authenticated by the dentist within twenty-four (24) hours after admission or prior to surgery or a procedure involving anesthesia, whichever is first.

g. Podiatric Records (excludes Libertas)
   1. For any patient who is normal and healthy (ASA 1 equivalent) or who has mild systemic disease with no functional limitations (ASA 2 equivalent), podiatrists may perform a complete admission H&P examination and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so and have been granted privileges by the Credentials Committee and Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with patient.
   2. For any patient with severe systemic disease (ASA 3 equivalent) or with severe systemic disease that is a constant threat to life (ASA 4 equivalent), a medical H&P examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
   3. The podiatrist shall be responsible for the podiatric surgery care of the patient, including the appropriate H&P examination, as well as all other appropriate elements of the patient's record.
   4. A legible copy of the podiatric history and complete exam performed in the office within thirty (30) days prior to admission may be incorporated into the medical record if authenticated by the examining podiatrist with an interval note (H&P update) indicating the patient was examined prior to surgery or a procedure involving anesthesia. Any additions, changes, "no change", etc. based on the interval exam are to be documented. This notation must be dated, timed and authenticated by the podiatrist within twenty-four (24) hours after admission or prior to surgery or procedure involving anesthesia, whichever is first.

h. Hospice Records (excludes Libertas)
   1. No H&P is required for hospice patients admitted for respite care.
   2. H&P is required for hospice patients admitted for acute care.

i. Palliative Care Records (excludes Libertas)
   1. No H&P is required for patients admitted for palliative care only.
   2. H&P is required for patients primarily admitted for reasons other than palliative care, where palliative care may also be an identified need.

j. Responsibility for the H&P: The H&P and update to the H&P (when an update is necessary) is the responsibility of the attending physician to complete and document or to make arrangements with another physician to do so. An ED record may not be used as an H&P.

k. The H&P examination may be performed independently, documented and signed by an APC with approved privileges that includes performing and documenting H&P's for countersignature by their sponsoring MSM. H&P exams may be performed independently, documented and signed by residents and interns as outlined in hospital policy *Residents and Interns - Patient Care Activities (D-39)*. In both cases, the H&P is countersigned by the sponsoring MSM. Exceptions: H&Ps documented by certified nurse midwives do not require countersignature. H&P's completed in a provider's office by an NP or PA within thirty (30) days prior to admission/registration, do not require countersignature.

l. Content of H&P
   a) History - include the following:
      - Chief complaint.
      - Present illness (includes symptoms/indications for the visit/surgical procedure).
      - Past medical history.
      - Past surgical history.
      - Family history (pertinent).
      - Social history (pertinent).
      - Review of systems (as appropriate to the encounter per provider discretion).
      - List of medications & dosages (unless available in EHR).
      - Allergies.
      - Admitting diagnosis.
      - Plan.
   b) Physical examination - Include as medically indicated:
      - HEENT.
      - Neck.
      - Breasts.
      - Heart.
      - Lungs.
      - Abdomen.
      - Extremities.
      - Neurologic.
      - Pelvic/genitalia, and rectal.
      - Mental status.
   c) An obstetrical record includes prenatal information, including history of complications, Rh determination, and other necessary information. Prenatal information may be provided on a legible office copy of the recorded information. An H&P update must be documented or written on admission, whether the delivery is vaginal or by C-section. See 6.1.l. for the content. (excludes Libertas).
   d) Newborn record content (excludes Libertas):
      - HEENT.
      - Heart.
      - Lungs.
      - Abdomen.
      - Extremities.
      - Neurologic.
   e) Content for outpatient diagnostic procedures requiring anesthesia services matches elements as listed on the Anesthesia Preprocedure Evaluation. (excludes Libertas).

6.2 Consultation (excludes Libertas)

a. A satisfactory consultation shall include a review of the EHR and examination of the patient and documentation of this in the record. The consultation report is documented in the EHR ***within*** twenty-four (24) hours of the consultation and in all cases prior to operative or medical procedure/delivery except in an emergency situation.

b. The patient's MSM is responsible for requesting consultation when indicated according to policy, *Medical Consultation (Required and Recommended)* (MS-009). Compliance is monitored by the Medical Staff through the appropriate departmental/clinical service chairpersons and the Medical Staff Executive Committee.

c. A credentialed NP/PA may perform and document inpatient assessments in the medical record. The sponsoring physician is required to document that he/she concurs with the assessment and that he/she has physically examined the patient and documented the consultation in the patient's medical record. Note: Consultations by NP/PA's credentialed to provide services in the Center for Wound Care and Hyperbaric Medicine and/or Palliative Services do not require countersignatures or concurrence by a physician.

d. Residents, interns and provider students may document consultations as outlined in hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).

6.3 Operative/Invasive/Procedure Reports (excludes Libertas)

a. Procedural Sedation Documentation- See *Sedation Policy (*D-26).

b. Anesthesia Documentation

1. Pre-Anesthesia Note
   a) A pre-anesthesia evaluation is completed by a credentialed anesthesiologist.
   b) At St. Clare's a Certified Registered Nurse Anesthetist (CRNA) may also complete a pre-anesthesia evaluation.
   c) At St. Nicholas a Certified Anesthesiology Assistant (CAA) may also complete a pre-anesthesia evaluation.
   d) The evaluation includes the following:
      1) A review of pertinent objective diagnostic data.
      2) Pertinent medical, anesthetic and drug history, and previous surgery.
      3) Review physical status, at least cardiopulmonary status (assessment).
      4) Pertinent lab reports.
      5) Plan of anesthesia (to include type of anesthetic).
   e) The pre-anesthesia note must be documented before surgery/procedure on the pre-anesthesia evaluation record prior to the patient's transfer to the operating suite from the Holding Room.
2. Intra-Procedural Anesthesia Documentation
   a) General, Regional and Monitored Anesthesia Care
      1) Documentation required by a credentialed anesthesiologist, CRNA or CAA on the patient's record includes the following:
         i. Recorded monitoring of the patient (pulse, respiration, O_2 Sat and blood pressure on the patient throughout the operation).
         ii. The dosage and duration of drugs and agents used, and the techniques used.
         iii. The type and amount of fluids administered, including blood and blood products.
         iv. Unusual events during the anesthesia period.
         v. The status of the patient at the conclusion of anesthesia.

   This documentation must be signed, dated and timed by the author. When a CRNA or CAA is involved, the report is signed by the CRNA or CAA **and** the Anesthesiologist. **Exception**: At St Clare's, the report is signed by the CRNA **or** the Anesthesiologist.
3. Post-Anesthesia Documentation
   a) A post-anesthesia evaluation is completed and documented on the Pre-Anesthesia Evaluation & Post-Anesthesia Note form by an individual qualified and credentialed to administer anesthesia.
   b) The post-anesthesia evaluation includes documentation of respiratory function, cardiovascular function, temperature, pain, nausea, post-operative hydration and mental status.
   c) The post-anesthesia evaluation is completed, signed, dated and timed within forty-eight (48) hours of surgery or prior to discharge in the case of an outpatient or ambulatory procedure patient.

c. Recovery Room Record
   1. A recovery room record is required for each patient admitted to the recovery room. The record shall contain vital data on the patient's condition following surgery and prior to transfer to the nursing unit. The patient's level of consciousness on arrival and discharge from the recovery room, the vital signs and, in appropriate situations, the status of infusions, all drugs administered, surgical dressing, tubes, catheters, and drains should also be noted in the record.
   2. The recovery room report must be signed by the responsible Registered Nurse (RN).

d. Operative Reports/Brief Op Note
   1. The provider performing the procedure is responsible for completing a written operative report/brief op note.
   2. If the Operative report/procedure note is not placed in the medical record immediately after surgery, a brief op note shall be entered in the record immediately after surgery (see 6.3.d.5.b) for content).
   3. Orthotists/Prosthetists who perform prosthetic and orthotic fittings/adjustments on patients are responsible for a written, signed operative note describing the technical procedure.
   4. An operative note written in the progress note is acceptable, particularly for local anesthetic cases.
   5. Content
      a) Operative Report
         1) The operative report shall contain:
            i. Name of the licensed independent practitioner (LIP) who performed the procedure.
            ii. Name of assistant(s) or other practitioners who performed surgical tasks (even when performing those tasks under supervision).
            iii. Pre-operative and post- operative diagnosis.
            iv. Name of the procedure.
            v. Type of anesthesia administered.
            vi. Description of the procedure (to include complications, if any).
            vii. Findings of the procedure.
            viii. Specimens removed.
            ix. Any estimated blood loss.
            x. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.
      b) Brief Op Note
         1. Elements of the brief op note shall include:
            i. Name of primary surgeon.
            ii. Name of assistant(s).
            iii. Procedure performed.
            iv. Description of each procedure finding.
            v. Specimens removed.
            vi. Postoperative diagnosis.
            vii. Estimated blood loss.
   6. Residents, interns and provider students may document operative reports/brief-op notes as outlined in hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).
   7. Timeframe
      a) The operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and is on the chart before the patient is transferred to the next level of care.
      b) Exception: When the brief op note is written immediately after the procedure, the full operative report is required to be completed within twenty-four (24) hours after the procedure.

6.4 Discharge Summary/Final Progress Note (for Libertas see X)
   a. A concise discharge summary is required for patients hospitalized more than two (2) days and for deaths. A discharge summary is not required for uncomplicated obstetrical patients, normal newborns, hospice patients admitted for respite care or palliative care patients primarily admitted for palliative care. See 6.4.g. for content.
   b. Patients hospitalized with minor problems or interventions (defined as less than two (2) day stay), uncomplicated obstetrical patients, and normal newborns require a final progress note. See 6.4.h. for content.

c. The discharge summary is the responsibility of the MSM who had the overall responsibility for direction of the patient's care for the majority of the stay, unless otherwise agreed upon by the MSMs involved in the care.
d. The MSM must see their patient the day of, or the day before discharge.
e. The discharge summary is to be documented within fourteen (14) days following discharge. Exception: When discharging to a nursing home or Community Based Residential Facility (CBRF), the discharge summary is to be documented before the patient leaves the hospital.
f. The discharge summary may be documented independently by APCs who have approved privileges. The summary is countersigned by the sponsoring MSM. Exception: Discharge summaries documented by nurse midwives do not require countersignature.
g. The discharge summary shall contain the following information:
    1. The reason for hospitalization.
    2. Care, treatment and services provided.
    3. Procedures performed.
    4. The condition and disposition of the patient on discharge.
    5. Instructions to the patient and/or family, if any.
    6. The principal diagnosis, together with any secondary diagnoses.
    7. Provisions for follow-up care.
h. The final progress note shall contain the following information:
    1. The outcome of hospitalization.
    2. Disposition of the case.
    3. Provisions for follow-up care.
    4. Principal diagnosis, together with any secondary diagnoses.
i. Residents, interns and provider students may document the discharge summary/final progress note as outlined in hospital policy; *Residents* and *Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).
j. A transfer summary is required for patients being transferred to the care of Rehab Services where the patient is not formally discharged from acute and admitted to the Rehab Unit/another hospital. It is to be documented within forty-eight (48) hours of the transfer of care.
    1. The transfer summary should contain the following information:
        a) The chief complaint and history of illness.
        b) Pertinent laboratory, radiology, clinical and physical findings.
        c) Medical and surgical treatment, including the patient's response, complications and consultations.
        d) The condition of the patient on discharge.
        e) The principal and secondary diagnoses, complications, infections, major operations/procedures.
    2. In those cases where a transfer summary is required, a discharge summary from the Physiatrist is also required. Content requirements are listed in '6.4.g. "Discharge Summary".
k. If a patient leaves the hospital against medical advice, these circumstances should be noted in the medical record.

6.5 Patient Care Orders
a. Inpatient orders
    1. Inpatient orders for patient care and treatment should be computer entered (or in writing) and signed by a MSM/APC involved in the care of the patient.
    2. Inpatient verbal and telephone orders are dated, timed and authenticated within forty-eight (48) hours by the MSM/APC responsible for ordering, providing or evaluating the service.
    3. Verbal/telephone orders are limited to situations where the MSM/APC is unable to write or electronically enter the orders and patient care needs require them.
    4. An order for care is on the chart at the time of admission.
    5. A transfer of care order should be documented and signed in the patient's medical record when the attending MSM transfers care to another attending MSM (See *Medical Staff Rules and Regulations*).
    6. Residents, interns and provider students may place orders as outlined in hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).
b. Outpatient Orders
    1. Outpatient verbal/telephone orders are dated, timed and authenticated within forty-eight (48) hours.
    2. Diagnostic and therapeutic procedures - Telephone or written outpatient orders are accepted from licensed physicians, licensed dentists and licensed podiatrists whether they are or are not MSMs.

Telephone or written outpatient orders are accepted from advanced practice nurses and certified physician assistants if they are credentialed as APCs or if they are licensed in the state of Wisconsin.

3. Orders are not required for self-referral mammography exams. (excludes Libertas)
4. Orders from Chiropractors: Physical and Occupational Therapy orders and diagnostic test orders received from Chiropractors licensed in Wisconsin may be accepted, however, payment and claims processing will be subject to the Centers for Medicare and Medicaid Services coverage rules. If ordering diagnostic tests, a medical physician's name is also provided at the time of ordering to provide any necessary follow-up. (excludes Libertas)
5. Out of state practitioners - Telephone or written orders from physicians, dentists and podiatrists licensed in another state can be accepted if the orders were prepared after examining the patient in that state and directed to be carried out in Wisconsin. (excludes Libertas)
6. For reference see policy, *Orders - Non-Staff Verification* (EWD) (MS-001). (excludes Libertas)
7. Out-of-country practitioners - orders are not accepted. (excludes Libertas)
8. Residents, interns and provider students may place orders as outlined in the hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).

c. Inpatient/Outpatient Orders

1. It is understood verbal and telephone orders are necessary at times. Verbal orders are to be used minimally in situations where it is not practical or reasonable to access a computer. Telephone orders are accepted when the MSM/APC is unable to access Epic. See policy, *Patient Care Orders Management* (EWD) (MS-025).
2. Verbal/telephone orders may be accepted and written in the EHR by the following: a RN; APC with an approved scope of practice/privilege that includes relaying written or verbal orders; ancillary medical services staff within scope of practice/delegated authority (i.e. Dietician, EKG Technician, EEG Technician, EMG Technician, Laboratory Technologist, Therapist in Acute Rehab/Inpatient Rehab, Case Management RN, Respiratory Care Practitioner, Radiation Therapist and Genetic Counselor.).
   Note: After patient evaluation per MD orders, Genetic Counselors may determine the need for specific clinical diagnostic laboratory tests. These clinical diagnostic laboratory tests may be entered as verbal orders for MD approval/signature.
3. Verbal or telephone orders are read back to the physician including the name and dosage of any drug.
4. Orders written by a MSM may be signed by another MSM who has been involved in the patient's care. APCs privileged to write/sign orders may sign orders of other APCs involved in the care of the patient. The provider who signs is legally and professionally responsible for the order.
5. Illegible, unclear, or incomplete orders will not be carried out until rewritten or clarified by the nurse. Vague phraseology ("renew," "repeat," "continue orders," etc.) should not be used.
6. Orders are automatically canceled whenever a patient is taken to surgery or is transferred to or from any of the special care units. (excludes Libertas)
7. APCs with an approved scope of practice/privilege may order according to the *Medical Staff Rules and Regulations* and their approved scope of practice/ privilege. Countersignature by MSM is in accordance with the *Medical Staff Rules & Regulations* and the APC's approved scope of practice/privilege. When a NP/PA orders tests/ treatments/medications for which they have privileges, these orders do not require countersignature by a doctor.
8. Policies governing renewal of medication orders are set by the Pharmacy and Therapeutics Committee.
9. MSMs and APCs shall not provide treatment for themselves or members of their immediate families except in situations outlined in policy on *Medical Staff and APC Treatment of Self or Immediate Family Members* (EWD) (MS-013).

6.6 Discharge Order (Inpatient, 1-Day patient)

a. Patients are discharged only by written or verbal order by a MSM involved in the care of the patient. Note: Psychologists do not discharge patients.

6.7 Order Modes (See policy, *Patient Care Orders Management* (EWD) (MS-025))

a) **Transcribed from Written Orders** are those that are written on paper, signed by a provider and entered by a proxy in circumstances preventing the use of Computerized Physician Order Entry (CPOE).

Example: No remote access to the EHR to directly enter orders. The signed paper copy is scanned into the EHR.

b) **Verbal with Readback** orders include patient care orders that were communicated verbally, face-to-face, by the ordering provider. Verbal orders should only be used to meet the urgent care needs of the patient when it is not feasible for the ordering provider to immediately provide the order in written form or electronically entered. They are to be read back to the provider to verify accuracy. Examples of acceptable use of verbal orders include: 1) When the provider is in the middle of a procedure or involved in patient care, 2) in emergent situations (i.e., codes) 3) when a nurse requests an order and it is not practical or reasonable for the provider to stop and enter the order him/herself. Verbal orders require a signature at subsequent time (includes date and time) to authenticate the order and should be completed by the provider before they leave the area.

c) **Telephone with Readback** orders are entered on behalf of a provider during communication via telephone call. They are to be read back to the provider during entry to verify accuracy. This provides opportunity for clarification if necessary. Telephone orders are acceptable only when 1) the provider is in another location within or outside the facility and does not have ready access to a computer and 2) when the provider has been contacted by hospital staff and it becomes necessary to change or add an order based on the patient's condition. Telephone orders require a signature within forty-eight (48) hours (includes date and time) to authenticate the order.

d) **Ordered during Downtime** orders are written by a provider, signed and dated during a downtime that are subsequently entered during the recovery phase. Verbal or telephone orders taken during a downtime are written on paper and entered as 'Verbal with Readback' or 'Telephone with Readback' and will queue for provider signature.

e) **Standard** - default order mode used when orders are entered directly by the authorized MSM/APC and authenticated as part of the order entry process. Also used by Pharmacists when editing or entering orders authorized by their role. No co-sign required.

f) **Standing Order (with co-sign)** is a standardized set of orders to be carried out when not in direct contact with a provider.

g) **Supply Order** is used to order patient supplies. No co-signature is required.

h) **Care Team Order (no co-sign)** is used by nurses or ancillary disciplines within their scope of practice to enter orders when the original order by the provider is already active (e.g. screenings such as MRSA, Pneumococcal, Influenza).

6.8 Time-frames for the Validity of Patient Care Orders are defined as follows:

a. Inpatient orders are valid throughout the patient's stay.

b. Pre-operative/pre-procedure (includes Interventional Radiology) orders are valid sixty (60) days from the date the order is written. If the surgery is canceled, the pre-op orders are canceled immediately. (excludes Libertas)

c. One-time outpatient and/or recurring outpatient orders/therapy plan orders are valid one year from the date the order is placed in the EHR.

d. Diagnostic mammography orders expire after one (1) year. Screening mammography orders do not expire (Patients can self-refer). (excludes Libertas)

e. Orders outside these time-frames are accepted if the order specifies the time and duration of the tests/treatments (e.g. in twelve (12) months, monthly for nine (9) months, prior to next appointment in October 20xx, within the next six (6) weeks, etc.).

6.9 Progress Note

a. The initial progress note should be an admission note and contain a provisional diagnosis and establish the patient's need for admission to the hospital.

b. The progress notes should record a timely picture of the patient's hospitalization including any changes in physical condition and comments on results of test and treatments ordered.

c. A progress note should be documented in the EHR as often as the patient's clinical condition warrants, and must be documented at least every twenty-four (24) hours by a credentialed and privileged MSM or a credentialed and privileged Advanced Practice Practitioner (PA-C, APRN, CRNA) working with the physician or physician group and working within their scope of practice. At a minimum, the MSM must assess the patient and document in the EHR the condition of the patient once every forty-eight (48) hours. Exceptions:

i. Hospice patients admitted for respite care and patients admitted primarily for Palliative Care do not require a daily progress note.

ii. In Inpatient Rehab, at least three days/week the physiatrist is required to make and document face-to-face visits throughout the patient's stay for the purpose of assessing the patient both medically and functionally as well as for modifying the course of treatment (see St. Vincent *Medical Staff Rules and Regulations, VII.2.*).
iii. A progress note is not required on the day of discharge if the physician has established a plan of discharge (e.g. pt. may be discharged tomorrow if specific criteria are met).
iv. Progress notes must be documented at least weekly. (Libertas only)

d. Progress notes must be dated, timed and signed.
e. Residents, interns and provider students may document progress notes as outlined in hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).
f. Psychologists can write and sign/date/time progress notes.
g. A final progress note by the responsible MSM or certified nurse midwives may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a two (2) day hospitalization, in the case of normal newborn infants, and in the case of uncomplicated obstetrical cases. See 6.4.h. for content.
h. Libertas only - Qualified colleagues (staff) enter progress notes in the patient's case record for each contact the colleague has with a patient or with a collateral source regarding the patient. Notes are entered to document the content of the contact with the patient or with a collateral source for the patient. Collateral Source means a source from which information may be obtained regarding a patient and may include a family member, clinical records, a friend, a co-worker, a child welfare worker, a probation and parole agent, or a health care provider.

Progress notes include:
i. Chronological documentation of treatment that is directly related to the patient's treatment plan.
ii. Documentation of the patient's response to treatment.

6.10 Documentation by Residents, Interns and Students
a. Residents, Interns and Provider Students see hospital policy; *Residents and Interns - Patient Care Activities (D-39)* and *Provider Students - Patient Care Activities* (D-38).
b. Clinical Students/Externs/Interns (nursing, respiratory therapists, dieticians, physical therapists, occupational therapists, etc.) - students granted access to document in the EHR are required to have their documentation co-signed according to policy *Students and Faculty* (AD-023).

6.11 Medical Records of Donors for Transplants (excludes Libertas)
a. 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.
b. When a cadaveric organ or cadaveric tissue is removed for purposes of donation, the removal is documented in the donor's medical record.
c. The Organ Procurement Coordinators (OPC) have order entry capability in Epic. The OPC will enter orders on brain dead organ donors using the 'Transcribed from Written'order mode based upon OPO medical director orders. These original orders are on file with the OPO. In the event there is an unforeseen downtime/Epic access is not available, orders will be faxed. RN's will enter the orders in this instance, and utilize the same 'Transcribed from Written' order mode.
d. See policy, *Organ Procurement* (GN-020).

6.12 Pathology Report (excludes Libertas)
a. Tissue and/or other material removed at the time of surgery and sent to the Pathology Department and examined by the pathologist unless specifically excluded from examination (See policy, *Tissue Exempt from Surgical Pathology Examination* (SS-001). The Pathology report is filed in the medical record within twenty-four (24) hours of completion of the report. The reports must be signed by the pathologist before being placed on the chart.

6.13 Diagnostic Radiology Reports (excludes Libertas)
a. The radiologist shall prepare an interpretive summary of the results of each X-ray/study as ordered. The original report, including a diagnosis is signed by the radiologist and filed in the medical record within twenty-four (24) hours of the test.

6.14 Radiation Therapy Reports (excludes Libertas)

a. Radiation therapy records are maintained in the Radiation Therapy Department. See policy *HIM - Radiation Oncology Record* (MR-010).

6.15 Ancillary Medical Services

a. Ancillary medical services (Dietary, EKG, EEG, EMG, Laboratory, Nuclear Medicine, Acute Rehab, Center for Wound Care & Hyperbaric Medicine, Case Management, Respiratory Therapy, Orthotics, Prosthetics, etc.) must document services and results of treatment. For the services providing recurring treatment, an initial evaluation, progress notes, attendance records, and a summary or discharge note are required. These are recorded in the EHR or on defined forms and signed by the health professional responsible for the entry.

6.16 Autopsy Report (excludes Libertas)

a. The autopsy report should contain pertinent information about the history and treatment recorded in the patient's medical record, a detailed report of the gross findings at autopsy, the microscopic findings, and the anatomic diagnosis.
b. Provisional anatomic diagnoses are recorded in the medical record within two (2) working days. The signed autopsy report should be placed in the record within sixty (60) working days of completion of the anatomic autopsy.

6.17 Nursing Documentation

a. The patient admission assessment is started on admission and completed within twenty-four (24) hours of admission by a RN. It serves as the basis for the plan of care. Orientation to the environment, appropriate screenings/assessments is completed per navigators in the EHR.
b. Documentation is completed by nursing colleagues as determined by patient population and reason patient presented. See policy *Nursing-Patient Assessment/Reassessment* (EWD) (MR-005).
    1. Nursing notes are written according to nursing plan of care. Nursing notes are signed electronically by the nurse entering the note.
    2. When a patient leaves the hospital AMA, the nurse or physician notes should reflect the time and the reason, if known, for departure. The AMA form should be signed by the patient and scanned to the record.
    3. At the death of a patient, the nursing documentation should include the time of death, the time of MSM notification, the name of the physician who pronounced the death, and disposition of the body.
c. Telephone encounters are considered a part of the patient's Legal Medical Record and are documented as follows:
    1. Follow up calls or results given to patients are documented in the corresponding encounter.
    2. A separate telephone encounter is created in the following instances:
        a) Patient calls the facility.
        b) The facility is providing information regarding a new read or diagnosis.

6.18 Documentation by Psychologists

a. Psychologists are MSMs but do not have admitting/discharge privileges and may not perform H&P's.
b. Orders may be written and must be signed by psychologists.
c. Progress notes may be written and must be signed by psychologists.
d. Psychologists will document the results of tests performed and/or consultations performed. The reports are signed and incorporated into the patient's medical record.

6.19 Discharge Instructions

a. Discharge instructions and discharge medication list are given to the patient and/or family member except in the event of death, leaving AMA or transfer.
b. The discharge instructions are signed and dated by the patient and are considered part of the legal medical record.
c. Discharge instructions are provided in written or electronic format, per patient preference.

VII.DOCUMENTATION - ALMOST HOME RECORD (Applies to HSHS St. Clare Memorial Hospital only)

7.1 Content
- a. Admission order.
- b. H&P completed within thirty (30) days prior to admission.
- c. Patients admitted from other facilities will have a Patient Plan of Care Evaluation and Referral form completed by the transferring facility.
- d. Documentation of a clinical visit to the swing bed patient within twenty-four (24) hours of admission. Almost Home progress notes, like skilled care, require documentation once every thirty (30) days or more if the patient's condition warrants it.
- e. All patients will have a nursing assessment completed by a RN.
- f. The MSM who had the overall responsibility for direction of the patient's care for the majority of the stay will document a discharge summary (see section 6.4.g. for the content requirements).

VIII. DOCUMENTATION - INPATIENT ASSESSMENT (Applies to Libertas only)

8.1 Assessment includes identification of alcohol and/or drug abuse, frequency of use, methods of administration and relationships to the patient's dysfunction. Psych-Social assessment includes available information on the patient's family, legal, social, vocational and educational history.

8.2 Assessment/Evaluation content:
- a. Nursing Assessment.
- b. History and Physical (See 6.1.l. for content).
- c. Psychological intake evaluation.
- d. Alcohol/drug use.
- e. Nursing intervention.
- f. Psych-Social assessment.

IX: DOCUMENTATION - TREATMENT PLANNING (Applies to Libertas only)

9.1 Inpatient
- a. Begins on day of admission.

9.2 Outpatient
- a. Begins with initial assessment.
- b. Reviewed at staffing at least every ninety (90) days or every thirty (30) days for patients who attend more than once a week.
- c. Signed by patient, counselor, clinical supervisor and physician.

X: DOCUMENTATION - DISCHARGE SUMMARIES (Applies to Libertas only)

10.1 A discharge summary will be entered into a patient's record within one (1) week after discharge.

10.2 Patient discharges and changes in levels of care will be discussed and reviewed in multidisciplinary treatment team staff meetings.

10.3 The discharge date will be the date when the patient no longer meets criteria for any level of care and is discharged with staff approval, or the date the patient is discharged against advice, or the date the patient is discharged at staff request.

10.4 The discharge summary shall include:
- a. A description of the reasons for the discharge and recommendations regarding care after discharge.
- b. The patient's treatment status and condition at discharge will be described.
- c. A final evaluation of the patient's progress toward treatment plan goals.
- d. The signature of the patient, the counselor, the clinical supervisor and if the patient is dually diagnosed the mental health professional, with the signature of the consulting physician included within thirty (30) days after the patient's discharge date.

DISTRIBUTION:

Medical Staff Members
Allied Health Professionals