AHMC ANAHEIM REGIONAL MEDICAL CENTER

(HEALTH INFORMATION MANAGEMENT SERVICES (HIMS))

MEDICAL RECORDS POLICY AND PROCEDURE

Adopted by the Medical Staff: July 27, 2009
Adopted by the Board of Directors: July 31, 2009
Amended by the Medical Staff: November 23, 2009
Amended by the Board of Director: January 20, 2010
# AHMC ANAHEIM REGIONAL MEDICAL CENTER

## HEALTH INFORMATION MANAGEMENT POLICIES AND PROCEDURES

### TABLE OF CONTENTS

1.0 GENERAL PRINCIPLES FOR MEDICAL RECORDS ................................................................. 2
2.0 RESPONSIBILITY FOR THE RECORD ..................................................................................... 2
3.0 CONFIDENTIALITY OF RECORDS ......................................................................................... 2
4.0 INFORMATION REGARDING HEALTH INFORMATION MANAGEMENT POLICIES ... 2
5.0 DESIGNATION OF ATTENDING PHYSICIAN ...................................................................... 2
5.1 Referring Physician ........................................................................................................... 3
5.2 Admitting H&P ................................................................................................................. 3
6.0 COMPLETION OF THE RECORD .......................................................................................... 3
6.1 Timely Completion ............................................................................................................ 3
   6.1.1 Incomplete Medical Records ....................................................................................... 3
   6.1.2 Delinquent Medical Records ....................................................................................... 3
   6.1.3 Action for non-timely completion of medical record ................................................... 4
6.2 Entries in the Medical Record ............................................................................................ 4
   6.2.1 Who Can Record Entries ............................................................................................ 4
   6.2.2 Verbal Orders .............................................................................................................. 4
   6.2.3 Signatures - Authentication ....................................................................................... 5
   6.2.4 Recording Entries in the Medical Records ................................................................. 5
   6.2.5 Abbreviations and Symbols ...................................................................................... 5
   6.2.6 Errors and Corrections ............................................................................................... 5
7.0 CONTENTS .......................................................................................................................... 6
7.1 The Inpatient Record ......................................................................................................... 6
   7.1.1 Identification sheets .................................................................................................... 6
   7.1.2 Initial diagnostic impression ...................................................................................... 6
   7.1.3 History and physical (H&P) examination .................................................................... 6
   7.1.4 Organ Donor .............................................................................................................. 6
   7.1.5 Consultation Requests and Reports: ......................................................................... 7
   7.1.6 Other sheets ............................................................................................................. 7
   7.1.7 Progress notes .......................................................................................................... 7
   7.1.8 Physician’s Pre-Op Invasive Procedure Checklist & Post-Op Invasive Procedure Note 7
   7.1.9 Operative reports ...................................................................................................... 8
   7.1.10 Anesthesia record .................................................................................................... 8
   7.1.11 Notes and reports .................................................................................................... 8
   7.1.12 Vital Sign Sheet ........................................................................................................ 8
   7.1.13 Restraint record ....................................................................................................... 8
   7.1.14 Tests and reports ..................................................................................................... 9
   7.1.15 Discharge Summary .............................................................................................. 9
   7.1.16 Face Sheet .............................................................................................................. 9
   7.1.17 Consent forms ......................................................................................................... 9
7.2 Outpatient Records .......................................................................................................... 9
7.3 Emergency Medical Services ............................................................................................ 10

### 8.0 AVAILABILITY OF RECORDS

8.1 Patients requesting access ............................................................................................... 10
8.2 Health Information may not be disclosed ........................................................................ 10
8.3 Release of Information from the Health Information Management Department to Parties
   Outside the Hospital .......................................................................................................... 11
8.4 Information Pertaining to Mental Health or Alcohol or Drug Abuse Treatment ................ 11
8.5 Removal of Medical Records from the Health Information Management Department .... 11
1.0 GENERAL PRINCIPLES FOR MEDICAL RECORDS
1.1 The Health Information Management serves a multitude of purposes, including providing data and information for patient care planning, continuity of patient care, quality assessment review, medical research and education, legal defense, and business record keeping.
1.2 Records must be maintained for all patients who receive treatment at the hospital, including inpatients, outpatients, and Emergency Department patients.
1.3 The medical record, including x-ray films and other documents maintained separately from the record, is the property of the hospital. The hospital has the legal responsibility to insure that it is complete, accurate, secure and confidential. The medical staff and all employees of the hospital are responsible for safeguarding the record and patient information against loss, alteration, defacement, tampering, or use by any unauthorized person, and adhering to and enforcing the Health Information Management Policies. Failure to comply with the Health Information Management Policies may result in loss of reimbursement for services, an inability to adequately defend against a claim for negligence or professional liability and/or licensing or accreditation sanctions or discipline against the hospital and/or responsible professional personnel. Under no circumstances will the medical record or microfilm leave the hospital except under Subpoena or Court Order, in which case the Manager of HIMS or designee will take the original documents to court.
1.4 This Health Information Management Rule should alert medical and hospital personnel to their responsibilities for maintaining medical records. It should be used in conjunction with the rules of each department; the Consent Manual published by the California Hospital Association (CHA), and licensure and accreditation standards (including the Patient's Bill of Rights).

2.0 RESPONSIBILITY FOR THE RECORD
2.1 The patient's attending practitioner and each practitioner involved in the care of the patient shall be responsible for preparing a complete and legible medical record for each patient.

3.0 CONFIDENTIALITY OF RECORDS
3.1 Medical records, or any part of the record, including records stored on microfiche or separately by hospital departments and divisions, shall not be removed from the hospital by any medical staff member or hospital employee except as required by law and approved by the Health Information Management Manager.
3.2 Patient identifiable information shall not be disclosed or released without the written consent of the patient or the patient's parent or guardian to any person not directly concerned with the care of the patient, except when disclosure is authorized by law.
3.3 Medical records may be reproduced only with the approval of the Health Information Management Manager. This applies also to any duplicate copies of the medical record maintained by other departments (such as laboratory and x-ray reports).

4.0 INFORMATION REGARDING HEALTH INFORMATION MANAGEMENT POLICIES
The Health Information Management Manager is responsible for providing information concerning access to and release of medical records, and all other policies regarding the maintenance of medical records at the Hospital. The Risk Manager is responsible for providing information concerning the obtaining of consent.

5.0 DESIGNATION OF ATTENDING PHYSICIAN
Attending Physician means the physician who has overall responsibility for the care of the patient during the patient's stay in the hospital. Note: For the twenty-four (24) hour period following open heart surgery, the primary Cardiothoracic Surgeon for the patient will be recognized as the designated “attending” physician and will have the overall responsibility for the care of the patient during that period of time, including coordination of care and communication among caregivers. Following the first twenty-four (24) hours, the overall responsibility for the care of the patient will revert to the “attending Physician.” This responsibility is often shared with other
physicians under the attending physician’s direct supervision.

5.1 **Referring Physician**

Referring physician. If applicable, the referring physician’s name shall be recorded on the medical record face sheet at the time of admission. If the name of a referring physician or primary care physician becomes available during the course of the patient's hospitalization, it shall be added to the face sheet in a timely manner.

5.2 **Admitting H&P**

Copies of dictated reports shall be forwarded to the PCP/Referring physician.

### 6.0 COMPLETION OF THE RECORD

6.1 **Timely Completion**

6.1.1 **Incomplete Medical Records**

a. The medical record shall be completed within fourteen (14) days after the patient is discharged. A completed medical record shall include the entry of all progress notes, reports, the principal diagnosis, a discharge summary and discharge data on the face sheet. **Exception:** For inpatient hospitalizations of less than 48 hours (including outpatient stays), a legible and complete “Discharge Summary for Patient Stay Less Than 48 Hours” form will be accepted in lieu of a dictated Discharge Summary. However, for expired and transferred patients, a dictated discharge summary is still required.

The HIMS Department is located on the first floor of the Hospital, and is open as follows:

Monday through Friday: 7:00 a.m. – 7:00 p.m.
Saturday: 7:00 a.m. – 3:30 p.m.

b. The Health Information Management Department should be called, preferably 24 hours in advance to allow time to collect incomplete charts.

c. Reports can be dictated by dialing from any in-house phone or by dialing in from an outside phone.

```
From in house phones:  Dial #302
From outside phones:  Dial (877) 776-0722 (toll free)
```

d. No medical staff member shall complete a medical record on a patient unfamiliar to him in order to retire a record of another staff member, even if the staff member is deceased or unavailable permanently or for an extended period.

The Health Information Management Committee Chairperson may retire the medical record only if the Attending physician is deceased, has moved from the area, has resigned from the medical staff, or is on an extended leave of absence.

6.1.2 **Delinquent Medical Records**

a. Hospital licensure regulations require completion of medical records within fourteen (14) days following the patient's discharge. Physicians who fail or refuse to complete or maintain hospital medical records may be subject to a suspension of clinical privileges until the incomplete medical records are complete.

b. A member of the medical staff will have twenty-four (24) Hours after his return to complete any medical charts that become delinquent while he is on vacation or incapacitated due to illness. All charts that are delinquent prior to vacation must be completed before leaving or the physician risks having medical staff privileges suspended while on vacation.

c. A practitioner’s clinical privileges (except for privileges to care for patients already in the Hospital or surgeries already scheduled) shall be automatically suspended for any of the following:

1) failure to complete a patient's entire medical record within fourteen (14) days after the patient's discharge

d. For purposes of this section, a failure to complete records will not be cause for suspension if, and during the time:

1) the member is ill, on vacation, or out of town for an extended period of time;
2) the practitioner has dictated the reports and is waiting for transcription to be completed.

6.1.3 **Action for non timely completion of medical record**

– see attached Policy and Procedure ORG 1001

6.2 **Entries in the Medical Record**

6.2.1 **Who Can Record Entries**

Entries in the medical record shall be made only by members of the medical staff, nursing staff, allied health professionals and hospital employees as authorized by the hospital and medical staff rules. 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.

Brief entries on the Doctor’s Progress Notes may be made by the Case Managers, Dieticians, Pharmacists and Speech therapists, these entries are limited to observations and other pertinent, non-medical information, related to the course of treatment and planning of continued care.

6.2.2 **Verbal Orders**

a. Verbal/telephone orders of authorized individuals may be accepted by RNs, LVNs, Pharmacists, OTs, PTs, Dietitians, Speech therapists, or RTs may accept verbal orders related to their licensure.

**ACCEPTING VERBAL/TELEPHONE ORDERS FOR MEDICATIONS** (see also ORG 309 and ORG 830):

Verbal or telephone orders for medications are received and recorded only by those health care professionals authorized to do so by their licensure or their scope of practice. The following health care personnel currently licensed, registered, or certified in the State of California shall be authorized to accept verbal or telephone orders for medications within their scope of practice.

i. Registered Nurse (RN)

ii. Licensed Vocational Nurse (LVN)– excluding blood products, total and peripheral parenteral nutrition, intravenous medications, and investigational medications

iii. Registered Pharmacists (RPh)

iv. Respiratory Care Practitioner (RCP)

v. Physical Therapist (PT) or Occupational Therapist (OT)

vi. Registered Dietitian (RD)

vii. Allied Health Professionals with practice prerogative privileges (see Allied Health Professional Rules and Regulations)

Verbal/Telephone Orders – Shall be recorded immediately in the patient’s medical record, noting the name of the person giving the verbal order and the signature of the person receiving the order. Orders are countersigned by the prescriber within 48 hours. It is acceptable for a verbal order to be cosigned by a physician covering for the ordering physician. By signing, the covering physician assumes responsibility for his/her colleague’s order as being complete, accurate, and final.

Physician’s Agent – Whenever possible, telephone orders are transmitted by the prescriber. Subject to the restrictions and credentialing rules and regulations of the Medical Staff, prescribers may authorize his/her agent or staff in their employee to transmit an order for a medication excluding Scheduled controlled medications. The name of the transmitter is included in the medical record. The prescriber countersigns the order within 48 hours. The recipient of a telephone order insists on speaking directly to the prescriber when appropriate or calls the prescriber back to confirm an order if any question about the legitimacy of a telephoned medication order occurs.

b. **Allied Health Professionals**, within their scope of practice and with appropriate practice prerogative privileges may transmit a supervising physician’s prescription for a medication verbally or in writing on a patient’s medical record. Such orders must comply with this policy, Pharmacy P&P (ORG 309 -Medication Management) and Nursing P&P (ORG 830-Physician Orders). All AHP orders must be countersigned within 24 hours.
c. Physicians’ verbal orders shall only be issued and accepted in case of emergency or if the physician is involved in a procedure. Physicians’ telephone orders shall only be accepted when the physician is off-site, unable to visit the patient care unit and unable to fax a written order. Faxed orders that contain physician signatures, date and time are considered complete orders and may be accepted.

6.2.3 Signatures - Authentication

a. The person writing an entry in the medical record shall be clearly identified by a legible signature and his/her professional designation (M.D., R.N., etc.) and service.

b. No hospital employee shall authenticate an entry for another person. The parts of medical record that are the responsibility of the medical practitioner are to be authenticated by him/her.

c. Entries shall be signed when they are entered or, if the entry is a verbal order, for medication other than over-the-counter drugs, it must be countersigned within forty eight (48) hours. (Faxed signatures for verbal medication orders are acceptable.)

d. It is also acceptable for a covering physician to co-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.

e. The Covering Physician is that 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.

f. If a progress note or an order was not signed within the required time, it must be "authenticated" as soon as possible.

g. Authentication of dictated reports (See Policy/Procedure on authentication of dictated medical reports)

6.2.4 Recording Entries in the Medical Records

a. All entries in the medical record shall be in ink and shall be legible or typed.

b. All entries in the medical record shall clearly identify the date and time of the entry. The date and time shall identify when the entry is made, regardless of whether it relates to prior events.

c. 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.

d. All patients must be admitted and discharged from facility by a physician order.

6.2.5 Abbreviations and Symbols

a. Abbreviations and symbols may be used in recording entries in the medical record only when the Health Information Management Committee, MEC and Governing Board have approved them. A list of approved medical record abbreviations and symbols shall be maintained in the Medical Records Department.

b. No abbreviations or symbols shall be used on the Discharge Face Sheet.

6.2.6 Errors and Corrections

a. Errors in the medical record shall be corrected by drawing a single line through the entry in such a manner that the erroneous entry is not obscured and writing "error".

b. Corrections may not be accomplished by erasure, page replacement, correction fluid, or any other means, which obscure the original entry.

c. All corrections shall be signed/initialed and dated.

d. Where there is insufficient space to make a correction on the same page as the erroneous entry, a note shall be inserted as close as possible to the error and a cross-reference inserted at the error site indicating the location of the correction.

e. In addition, all blanks left in dictated reports must be filled in when the report is authenticated. Any cross-outs with or without re-entries should be noted as "error", dated and initialed.
7.0 CONTENTS
Each record shall contain sufficient detail and be organized in a manner, which will enable a subsequent treating physician or other health care provider to understand the patient's history and to provide effective care.

7.1 The Inpatient Record

7.1.1 Identification sheets
The Admission Data Sheet (face sheet) shall include sociological and demographic information.

7.1.2 Initial diagnostic impression
which shall be a concise statement of the complaints which led the patient to consult with the physician, and the date and onset and duration of each, and a provisional diagnosis, which is the impression (diagnosis) reflecting the examining physician's evaluation of the patient's condition based upon the physical findings and history.

7.1.3 History and physical (H&P) examination
which shall include all positive and negative findings from an inventory of systems. The history and physical shall include the following information: Chief complaint; details of present illness, relevant past, social and family histories, review of system as appropriate to the age of the patient, a summary of patient's psychosocial and mental status and needs allergies. The H&P shall be dictated no later than twenty-four (24) hours after the patient's admission, unless the patient will be taken to surgery sooner, in which case the H&P report must be placed in the patient's chart before the patient is taken to surgery. If it is not possible to have a dictated H&P transcribed and placed in the chart prior to surgery, the nurse in the prep room will put a short form H&P in the chart for the physician to fill out and will not move the patient in to surgery until it is completed.

A complete H&P examination may be performed up to thirty (30) days prior to the patient's admission to the hospital provided the physician updates the information immediately prior to or within twenty-four hours after admission. A reasonably durable legible copy of the report of that examination may be used in the patient's medical record in lieu of an admission H&P report. For surgeries or invasive procedures, there must be an update to the H&P that documents whether or not there are any significant changes that occurred within 24 hours prior to the surgery or invasive procedure. The Medical Staff member must also document any pertinent clinical changes in the patient's condition at the time of admission.

If the patient is readmitted to the Hospital within thirty (30) days of a previous discharge for the same or related condition, an interval admission note stating the reason for readmission and any changes in the H&P report may be written in lieu of a complete H&P report. A copy of the prior H&P shall be placed in the patient's medical record.

The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the hospital before admission. An interval admission note shall be written that includes pertinent additions to the history and a physical examination should be performed upon admission to the hospital. A short form H&P may be acceptable for OB/GYN patients who are admitted for less than twenty-four (24) hours. A combined short form history/physical/progress note/doctor's order may be used for outpatient procedures and day care patients.

In the case of newborns remaining in the hospital for less than 24 hours, the Transfer Summary can be combined with the History & Physical. To accomplish this “Transfer Summary” will be added to the “History & Physical” at the top of the form.

7.1.4 Organ Donor
When the donor is obtained at AHMC Anaheim Regional Medical Center from a brain-wave death patient, the medical record of the donor shall include the date and time of brain-wave-death, documentation by and identification of the physician who determined the death, the method of transfer of the organ, and the method of machine maintenance of the patient for organ donation, as well as an operative report.
7.1.5 **Consultation Requests and Reports:**
i.e. a written opinion signed by the consultant including his findings on physical examination of
the patient or of other data and information. The consultation report shall be completed and
filed in the medical record within forty-eight (48) hours of examination. (See rules and
regulations pertaining to consultations).

If a staff member is quoted in the patient's medical record as a consultant, a formal report of
the opinion prepared by the consultant must be made a part of the patient's medical record.

7.1.6 **Other sheets**
including medication, medication reconciliation, treatment and diet orders. (See also the rules
and regulations pertaining to Orders and Medication Orders).

7.1.7 **Progress notes**
which shall be made on at least a daily basis. The progress notes shall give a chronological
picture of the patient's progress and be sufficiently detailed to permit continuity of care and
transferability. The progress notes shall delineate the course and results of treatment. The
condition of the patient shall determine the frequency with which the progress notes should be
made (but no less than daily).

A patient must be seen within 24 hours prior to discharge with a note having been written on the
chart.

A newborn remaining in the Hospital awaiting mother's discharge does not require daily
visits/progress notes after initial examination. Chart must document that "baby is remaining in
the Hospital awaiting mother's discharge and that baby is well without problems".

7.1.8 **Physician's Pre-Op Invasive Procedure Checklist & Post-Op Invasive Procedure Note**
A physician must complete the Pre-Op Invasive Procedure Checklist prior to a surgery or
invasive procedure being done and must complete the Post-Op Invasive Procedure Note
immediately following the procedure.

This form does not replace the need for a dictated Operative Report immediately following a
surgery or invasive procedure. However, it does provide pertinent information for use by other
members of the medical staff and AHMC Anaheim Regional Medical Center care team who are
responsible for attending the patient.

**Pre-op Checklist includes:**
- H&P or pre-natal record (within guidelines specified in section 7.1.4) is in the medical
record.
- Informed Consent guidelines have been met
- Blood Transfusion Guidelines were met (if applicable)
- If Hysterectomy – Informed Consent Guidelines were met
- If Breast Cancer (Surgery) Treatment – Patient has received the DHS pamphlet
- If Elective Sterilization – Patient has received DHS pamphlet and verbal information
- H&P update – Note any changes in patient condition since the H&P was documented
  (See “Short Form H&P” can be written if you have completed one per section 7.1.4)
- Physician Signature and Date

**Post-op Invasive Procedure Note includes:**
- Pre-Operative Diagnosis
- Post-Operative Diagnosis
- Operative Procedure(s)
- Surgeon
- Assistant(s)
- Anesthesiologist
- Anesthesia Type/Method (Local, Regional, General)
- Findings
- Complications
- Condition
- Miscellaneous (ie., closure, dressing, tubes, drains, blood loss, specimens, fluids)
7.1.9 Operative reports

including preoperative and postoperative diagnosis, preoperative and postoperative findings, a description of the techniques used a description of the findings, a notation of any tissues removed or altered.

The operative report shall be dictated immediately after completion of surgery.

The operative report shall be completed for outpatients as well as inpatients.

7.1.10 Anesthesia record

including preoperative diagnosis if anesthesia has been administered (See Anesthesia Rules and Regulations).

The preanesthesia evaluation shall include pertinent information relative to the choice of the anesthetic agent or technique and the surgical procedure anticipated, and the patient's previous drug history, other anesthetic experiences, and any potential anesthetic problems. Except in emergency cases, the preanesthesia evaluation shall be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

In the Same Day Surgery unit, the preanesthesia evaluation shall be recorded before preoperative medication has been administered or, if the patient is not to receive preoperative medication.

Pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia shall be recorded in the medical record. These include dosage and duration of all anesthesia agents, other drugs, intravenous fluids, and blood or blood components.

The record shall identify the physician responsible for the patient's release when there has been no written order, or an authenticated verbal order, by the responsible physician. The anesthesiologist shall enter a note recording a post-anesthetic visit. The note shall describe the presence or absence of anesthesia related complications.

7.1.11 Notes and reports

from the nursing, ancillary and support staff and services involved in the patient's care. The notes should record pertinent observations of psychosocial and physical manifestations, as well as any incidents.

Duplicate reports will be maintained in each ancillary department. Such documents shall be subject to the same confidentiality standards.

a. Nuclear radiology records shall identify the type and amount of radio-pharmaceutical used, the date of administration, and any special preparation of the patient.

b. When laboratory tests are performed in a reference laboratory, the name of the laboratory performing the test shall be included in the report entered in the medical record.

c. Diet orders shall be recorded in the medical record before the diet is served to the patient.

d. The documentation for occupational therapy shall include the modalities, and the frequency and duration of treatment.

e. Social Services documentation should address:
   • observations and social assessment of the patient and, as relevant, of the patient's family;
   • proposed plan for providing any required social work services;
   • any social therapy/rehabilitation provided the patient and the patient's family;
   • social work summaries, including any recommendations for follow-up;
   • Relevant information concerning home environment evaluations for the Attending practitioner, cooperative activities with community agencies, and follow-up reports.

7.1.12 Vital Sign Sheet

shall be completed in detail and in a timely manner.

7.1.13 Restraint record

shows type of restraint and time of application and removal (see restraint policy in Medical Staff Rules and Regulations).
7.1.14 Tests and reports
Any laboratory, radiographic, or other diagnostic reports from outside laboratories or other facilities, which include results pertinent to the patient's current hospitalization. These records shall be made a permanent part of the patient's medical record.

7.1.15 Discharge Summary
All inpatients are required to have a dictated Discharge Summary (see exceptions below) which briefly recapitulates the reasons for hospitalization and describes the significant findings, and events of the patient's hospitalization, the procedures and treatment rendered; the condition of the patient on discharge; and any specific instructions and orders for follow-up care given to the patient and/or family. When preprinted discharge instructions are given to the patient or family, a carbon copy shall be entered in the medical record, which has been signed by the patient, patient's parent or legal representative and witnessed.

NOTE: An AHMC - ARMC physician is allowed to hire another AHMC - ARMC physician to dictate their discharge summaries as long as they co-sign and authenticate the accuracy of such dictation.
Nurse Practitioners and Physician Assistants under the auspices of the Department of Cardiology, Surgery and Women's and Children's Services may dictate discharge summaries. Discharge summaries must be countersigned by the supervising physician(s) within fourteen (14) days of discharge. Nurse Practitioners and Physician Assistants under the auspices of the Department of Medical Services are not allowed to dictate discharge summaries.

The physician who attended to the care of the patient for a substantial amount of time during the current hospital stay as primary attending physician is responsible for: 1) completing the Discharge Summary; or 2) arranging for another physician to complete the Discharge Summary. Any delinquency in the timely completion of the discharge summary is the responsibility of the physician who attended to the care of the patient for a substantial amount of time during the current hospital stay as primary attending physician, and may result in suspension of privileges.

Exceptions to 7.1.15:
A final progress note may be substituted for the Discharge Summary in the case of normal newborn infants (Boar der Babies) or their mothers of uncomplicated obstetric deliveries, c-sections, and maternal conditions that delay a newborn discharge over 48 hours. (modified 1/20/2010).

For inpatient hospitalizations of less than 48 hours (including outpatient stays), a legible and complete “Discharge Summary for Patient Stay Less Than 48 Hours” form will be accepted in lieu of a dictated Discharge Summary. This includes patients with normal deliveries electing to have a tubal ligation and staying the hospital for less than 48 hours. However, for expired and transferred patients, a dictated discharge summary is still required.

When a discharge summary concerns a patient treated for alcohol and/or drug abuse or mental illness, a copy of the discharge summary shall be forwarded to any physician and/or health facility known to be responsible for the subsequent medical care of the patient. A discharge summary concerning a patient treated for alcohol or drug abuse or mental illness may be disclosed to professionals outside of the Hospital if the patient or his legal representative consents, in writing, to the disclosure.

7.1.16 Face Sheet
a. The discharge data face sheet shall contain all relevant diagnoses, complications operative procedures and infections.

b. No abbreviations or symbols shall be used in completing the discharge data face sheet.

7.1.17 Consent forms
(See the rules pertaining to Consent for Treatment).

7.2 Outpatient Records
Each outpatient record, except radiology, pathology and similar diagnostic services, shall include the
following elements:

7.2.1 Identification sheet (see 7.1.1 above).
7.2.2 A record of the patient's medical history (see 7.1.3 above).
7.2.3 A physical examination report (see 7.1.3 above).
7.2.4 Consultation reports (see 7.1.5 above).
7.2.5 Clinical notes, including the dates and time of visits.
7.2.6 A record of treatment and instructions, including notation of any prescriptions written, diet instructions, if applicable, and self-care instructions.
7.2.7 Reports of all ancillary services, including laboratory tests, pathology reports, if tissue or body fluid was removed, and x-ray examinations.
7.2.8 If an operation was performed, a written record of preoperative and postoperative instructions; an operative report on the outpatient surgery describing the techniques used, the findings, and tissue removed or altered, as appropriate, and an anesthesia record, as is required by the Anesthesia rules (see 7.1.7 and 7.1.8 above).
7.2.9 Referral information from other providers.
7.2.10 Consent forms (see rules regarding Consent for Treatment).

7.3 Emergency Medical Services
Medical records shall be maintained on all patients presenting for emergency medical care. The medical record shall include:

7.3.1 Patient identification. When not obtainable, the reason shall be entered in the medical record.
7.3.2 Time and means of arrival.
7.3.3 Pertinent history of the illness or injury, and physical findings, including the patient's vital signs.
7.3.4 Emergency care given to the patient prior to reaching the hospital.
7.3.5 Diagnostic and therapeutic orders.
7.3.6 Clinical observations, including results of treatment.
7.3.7 Reports of procedures, tests and results.
7.3.8 Diagnostic impression.
7.3.9 Conclusion at the termination of evaluation/treatment, including final disposition, the patient's condition on discharge or transfer, and any instructions given to the patient and/or family for follow-up care.

8.0 AVAILABILITY OF RECORDS
Records shall be maintained safely by the Hospital. Each practitioner shall respect the confidentiality of physician-patient communications, information obtained in the course of diagnosing and treating patients, and in medical records.

8.1 Patients requesting access
to their own records shall be referred to their attending physician. However, the Health Information Management Department shall assure that the patient is granted access, through a copy, inspection, or a summary, in accordance with the law governing patients' access to their records.

8.1.1 Whenever possible, the medical record shall not be released to the patient, or to the patient's parent or guardian, except during a conference with the Attending physician, when the physician can explain and interpret the record.
8.1.2 Health Information involving treatment to which a minor has legally consented may not be released to the minor's parent or guardian unless the minor consents. Minors may consent to their own medical treatment in several situations. Please see chart attached from Consent Manual in the rule pertaining to Consent.

8.2 Health Information may not be disclosed
without the patient's written permission except when the law allows disclosure. The most often involved exceptions allow disclosure, without authorization to:

8.2.1 Hospital personnel and other medical personnel involved with patient examination, treatment, and follow-up care
8.2.2 Hospital personnel and third party payors involved with third party reimbursement
8.2.3 The Hospital's auditor, attorney and liability insurer
8.2.4 Administration and the Executive Director
8.2.5 Medical Staff and Hospital Committees responsible for reviewing quality of care at the Hospital
8.2.6 Risk Manager
8.2.7 Quality Review staff
8.2.8 Department of Pathology
8.2.9 Coroner’s Office

8.3 Release of Information from the Health Information Management Department to Parties Outside the Hospital.

Information contained in a patient's medical record shall not be revealed to anyone other than the parties enumerated in Section 8.2 above until the Medical Records Department has been contacted and approves. Generally, written authorization from the patient or the patient's parent or guardian must be obtained before information may be released. Great care should be taken when disclosing highly sensitive medical records, such as those involving pregnancy, abortion, sexual child abuse, venereal disease or emancipated minors. In certain circumstances, the hospital is entitled to processing fees.

8.4 Information Pertaining to Mental Health or Alcohol or Drug Abuse Treatment.

8.4.1 Strict confidentiality laws protect information pertaining to treatment for mental disorders or alcohol or drug abuse. Questions about whether these laws apply to a record should be referred to and answered by the Manager of Medical Records.

8.4.2 Release of information pertaining to mental illness: see Consent Manual.

8.5 Removal of Medical Records from the Health Information Management Department

8.5.1 Each medical record removed from the Health Information Management Department shall be signed out to a designated individual. This individual is personally responsible for the security of the medical record while it is in his/her possession and for the return or transfer of the medical record.

8.5.2 No medical record shall be held longer than 24 hours.

8.5.3 Health Information Management Department personnel shall contact the individual who has a record signed out in order to retrieve the record for a requesting individual.

Medical Executive Committee: November 23, 2009

Board of Directors: January 20, 2010