

**Sutter Medical Center, Sacramento
Medical and Allied Health Staff**

**Medical Record Documentation
Education Module: Key requirements for
provider documentation at SMCS**

**Safe Patient Care :
Communication is the key;
Documentation is the tool**

*At the conclusion of this education module, a quiz
must be successfully completed.*

MEDICAL RECORD ENTRIES and LEGIBILITY

The Centers for Medicare & Medicaid Services (CMS) and the Joint Commission for Accreditation of Health Care Facilities (JCAHO) require ALL medical record entries be **LEGIBLE, TIMED, DATED and AUTHENTICATED.***

In addition, SMCS Medical Staff Rules and applicable policies state that all documentation in the medical record **MUST** be clear and legible. The signature of the person making the entry shall be accompanied by the person's printed or stamped name or dictation number for purposes of authentication unless the author's signature is unequivocally legible.

The standard used to determine legibility: Two staff must be able to read it.

HOW TO COMPLY

1. Write legibly in the medical record.
2. Date, time and sign and print or stamp your name or dictation number on all your medical record entries – orders, notes, etc. ***DO NOT PRE OR POST DATE ANY MEDICAL RECORD ENTRY***

COLLABORATIVE PRACTICE:

1. Review your orders with a nurse before you leave the nursing unit. This should alleviate confusion by allowing for immediate clarification.
2. You can use a scribe as long as you immediately co-sign your order or notes. The staff at SMCS cannot be used for this purpose.

PLEASE NOTE: You may anticipate being called by the unit nurse or the pharmacist for clarification of illegible and/or incomplete orders.

*Source: CMS Interpretive Guidelines for Hospitals §482.24(c)(1); JCAHO Hospital Accreditation Standard MM.3.20; Medical Staff Communication Policy

TELEPHONE MEDICATION ORDERS

ALL telephone medication orders must be authenticated **100% of the time within 48 hours.** This is a state law: California Code of Regulations, Title 22, Section 70263. It is also required by CMS and the JCAHO. Authentication requires a date, time and signature.

The physician who gave the telephone order is responsible for assuring authentication of that order. However, any physician participating in the care of the patient can authenticate the medication telephone order.

Important Note:

1. The medical record will now be considered incomplete if you do not comply with the documentation requirement.
2. Verbal orders are only accepted under emergency situations.

HOW TO COMPLY

1. The nurse will read back the telephone order at the time it is given. This is your opportunity to clarify or change the order. To ensure patient safety, your active participation is required in the “read-back” of orders.
2. Review the record for any telephone orders during your daily rounds; these are identified with a yellow sticker. After reviewing the order, you must sign, date and time where indicated on the telephone order.

COLLABORATIVE PRACTICE

1. The RN taking the order will place a yellow sticker at the bottom of the order, indicating the name of the person taking the order, the date and time. There is a space for the physician to authenticate with signature, date and time.
2. If there is any question about the telephone order, immediately bring it to the attention of the Charge RN.

Source: 42 CFR 482.23(c)(2)(ii); CMS Position Statement April 19, 2001, California DHS Clarification to CCR Title 22, 70263(g) and 71233(g), California Business and Professions Code Section 4019, Medical Staff Rules and Regulations Section XXVIII, JCAHO Hospital Accreditation Standard IM.6.50, JCAHO National Patient Safety Goal 2A.

UNSAFE ABBREVIATIONS

Patient Safety is of critical importance to all who work in the health care field. Specific abbreviations attached to medications have resulted in patient harm due to medical error. As a result, the Joint Commission now prohibits the use of these unsafe abbreviations throughout the medical record. The Patient Safety Team and the Medical Executive Committee have approved this list.

UNSAFE	SAFE
IU	Unit
U	Unit
Zero absent before decimal point e.g. .2	Leading zero before decimal point. e.g. 0.2
Zero after decimal point e.g. 2.0	No zero after decimal point. e.g. 2
Q.D or Q.O.D.	Write “daily” or “every other day”
MS MSO4 MgSO4	Write “morphine sulfate” or “magnesium sulfate”
c.c.	Write “ml” for milliliters

HOW TO COMPLY

1. Write clear and legible medication orders using the “safe” nomenclature.

COLLABORATIVE PRACTICE

1. The **unsafe abbreviation** list is included on every order sheet and in the chart divider.
2. Orders with **unsafe abbreviations** will not be implemented. The order will have to re-written by the ordering physician.

Source: JCAHO National Patient Safety Goal 2B; Medical Staff Communication Policy

HISTORY & PHYSICAL REQUIREMENTS

INPATIENT

1. An admission history and physical must be written or dictated **within 24 hours of admission**. An admission note shall be made as soon as possible. Your Admission note should indicate "H&P dictated," as appropriate.
2. The dictated H&P must be reviewed for accuracy and completeness at the time of authentication. Any blanks in the H&P due to transcription issues must be completed. Simply write in the word(s) that were unclear.

ALL OPERATIVE OR INVASIVE PROCEDURES, (Inpatients and Outpatients) must have:

1. An H&P performed within last 30 days must be present in the chart
 - Exceptions:
 - Inpatients who have ongoing progress notes
 - Patients whose current, most recent pre-natal records are on the unit
2. For those minimally invasive procedures (i.e. colonoscopy), a “short-form” H&P may be used. All elements on the short form must be completed. A signature, date and time is required.
3. An update to the H&P must be made immediately prior to any invasive procedure, documenting a second exam to determine any changes in the patient's medical status or medication use. The operating physician can simply write “No changes in H&P” followed by a signature, date and time on the H&P.
 - Pre-anesthesia assessment by an anesthesiologist will serve as the H&P update at the anesthesiologist's discretion.
4. A complete history and physical examination may be submitted by non-staff SMCS physician as long as the following is met:
 - The H&P is within 30 days of admission
 - The admitting physician dates and signs the H&P and notes that he/she has reviewed the H&P and found it to be acceptable.

Procedures will be cancelled if the H&P is not within the guidelines.

ADDITIONAL INVASIVE PROCEDURE REQUIREMENTS

Pre-anesthesia/Pre-sedation documentation

All patients undergoing a procedure requiring anesthesia or sedation are required to have a pre-procedure assessment to establish the appropriateness of the planned sedation/anesthesia for the patient. Completing the sedation form used in the service ensures all required elements are met. Anesthesiologists use the Anesthesia Evaluation form. Documentation must include:

- An assessment by the attending anesthesiologist/physician
- An airway assessment
- An IMMEDIATE reassessment. In most cases this is the nurses' recorded vital signs, which must be validated by physician signature or initials

Universal Protocol (required for ALL operative or invasive procedures)

- When appropriate, the correct site will be marked and verified by the surgeon's initials before the patient enters the procedure/surgical room.
- Immediately prior to the procedure, the entire procedural or operative team must conduct a timeout to verbally verify correct patient, procedure, and side/site/level, patient position, and availability of correct implants and any special equipment or special requirements.

Immediate Post Procedure/Surgery Note

IMMEDIATELY AFTER the procedure (upon completion of the operation or procedure, before the patient is transferred to the next level of care), a note must be **written** with the description of the procedure, any complications, estimated blood loss, condition of the patient and findings of the procedure. The post surgical note provides critical information about the patient's intraoperative management, supports patient safety and eliminates unnecessary calls to the surgeon.

Name: _____ Department: _____

Medical Record Documentation Education Module Quiz

1. **One is in compliance with CMS and The Joint Commission requirements only when all medical record entries (orders, notes, etc.) are:**
 - a. legible
 - b. dated AND timed
 - c. authenticated
 - d. all of the above

2. **Telephone medication orders must be signed, dated and timed:**
 - a. Within 48 hours unless the chart has gone to Medical Records
 - b. Within 48 hours unless the physician is on vacation
 - c. Within 48 hours unless interrupted by a weekend or national holiday
 - d. Within 48 hours, period!

3. **Authentication of a telephone order can be signed by:**
 - a. A charge nurse
 - b. A JCAHO surveyor
 - c. A Pharmacy Ph.D.
 - d. By a physician, even if he/she does not have privileges on this campus.
 - e. By any SMCS Medical Staff member responsible for the patient or who can attest that the order is accurate, complete and final.
 - f. All of the above

4. **A simple way to identify and authenticate a telephone order is to:**
 - a. Look for the yellow sticker on the medical record
 - b. Look for the blue sheet
 - c. Look for the green-striped sheet
 - d. Ask a non-color blind colleague for help

5. **Unsafe abbreviations:**
 - a. Are only prohibited in physician orders
 - b. May only be used if you're in a hurry
 - c. Are in place to annoy physicians
 - d. Are prohibited anywhere in the medical record

6. **Operative or Invasive Procedure H&P's:**
 - a. Must be performed within 30 days of the procedure
 - b. Can be older if accompanied by daily inpatient progress notes or a current pre-natal record
 - c. Always require a re-examination and documented update before a procedure
 - d. May be accepted from non-staff physicians with surgeon's re-examination note and signature
 - e. All of the above.

Medical Record Documentation Education Module Quiz

7. **A post-operative note needs to be written:**
 - a. Immediately after the procedure
 - b. Within 24 hours
 - c. Can be dictated if the transcription can be completed within 12 hours
 - d. Must be printed by hand
 - e. All of the above

8. **An immediate post-operative note must be in place and include date, time, procedure, findings, patient's condition, surgeons, tissue removed, blood loss, etc.:**
 - a. So information to answer questions regarding the patient's intraoperative management is immediately available
 - b. To support patient safety
 - c. To eliminate the unnecessary call to the surgeon
 - d. Because the surgeon may not be immediately available to answer questions regarding that surgery
 - e. All of the above.

9. **Authentication of medical entries requires, dating, timing and:**
 - a. A legible signature readable by 2 staff
 - b. A printed or stamped name, or medical staff number
 - c. Either a. or b.

10. **Time outs immediately prior to a procedure**
 - a. Must include all members of the operative team, who cannot be engaged in other activities at the time
 - b. Require active verbal participation
 - c. All of the above

Signed: _____

Name of physician/AHP: _____
(Please Print Legibly)

Date Quiz Completed: _____