RULE 002: MEDICAL RECORDS

A. EMERGENCY RECORDS: There shall be an emergency record prepared on every patient seen in the emergency department.

B. MEDICAL RECORDS CONTENT: The attending practitioner will be held responsible for the preparation and completion of the medical record for each patient. The medical record will contain information needed to support the patient’s diagnosis and condition, justify the patient’s care treatment and services, document the course and results of the patient’s care, treatment, and services, and information that promotes the continuity of care among providers.

A complete medical record, as agreed upon by MHM Osteopathic Principles Committee and Medical Executive Committee includes:

1. Identification: Demographic information as follows:
   - Patient’s name
   - Address
   - Date of birth
   - Gender
   - Name of any legally authorized representative
   - Legal status of any patient receiving Behavioral Health Care Services
   - Patient’s language and communication needs

2. Chief Complaint: There shall be a concise statement of the complaints which led the patient to consult his/her physician and the duration of each;

3. History: This shall consist of the history of present illness, past history, systems review, family history and social history, and any allergies to food or medications.

4. In Regard to Services for Children and Adolescents: An evaluation of the patient’s developmental age, consideration of educational needs and daily activities, as appropriate, the parent’s report or other documentation of the patient’s immunization status, and the family’s and/or guardian’s expectations for, and involvement in, the assessment, treatment and continuous care of the patient.

5. Physical Examination: There shall be a statement, including pertinent positive and negative findings resulting from an inventory of systems, including an osteopathic musculoskeletal exam if the admitting physician is an osteopathic physician for all inpatient admissions.

6. Preliminary Diagnosis: This shall be an initial impression or working diagnosis.

7. Progress Notes: Progress notes shall give a chronological picture of the patient’s progress, shall be sufficient to delineate the course of treatment, and shall be written or entered electronically at least daily (exception Rehab Unit). Progress notes shall be dated and timed.

8. Treatment, Medical & Surgical: All treatment procedures shall be documented in the medical record. Except in cases of grave emergency, the patient should
RULE 002: MEDICAL RECORDS

receive an appropriate diagnostic workup before surgery.

9. **Inpatient Diagnostic/Treatment Orders:** All orders for inpatient treatment shall be in writing or electronically documented. An order shall be considered to be in writing if dictated to a registered nurse (R.N.); such orders shall be signed by the person to whom it was dictated with the name of the physician initiating the order utilizing the readback process described below in D.2.

10. **Final diagnosis:** A definitive final diagnosis shall be expressed in terminology of a recognized system of disease nomenclature. All final diagnoses shall be written in full without abbreviations.

11. **Discharge summary:** The discharge summary shall be a recapitulation of the significant findings and events of the patient’s hospitalization to include: reason for admission, procedures performed and treatment rendered, complications during hospitalization, condition on discharge, recommendations or instructions to the patient, discharge medication(s), and arrangements for future care. Discharge summary must be dictated or completed electronically for stays greater than forty-eight (48) hours. A discharge note shall be written or entered electronically in the progress notes for uncomplicated inpatient stays of forty-eight (48) hours or less.

12. **Documents:** All documents, such as lab reports, x-ray reports, consultations, nursing observations, dietary reports, physical therapy reports, autopsy reports, etc., shall become permanent parts of the medical record.

C. **OBSERVATION PATIENTS:** The medical record for observation patients shall include:
- Reason for hospitalization;
- Progress during stay;
- Discharge instructions/followup.

D. **MEDICAL RECORDS DOCUMENTATION REQUIREMENTS:**

1. **Signatures:** All orders and entries shall be authenticated by the responsible practitioner. Signature stamps may not be used to authenticate any part of the medical record. Orders and entries by non-credentialed providers and/or credentialed non-physician providers shall be countersigned by the supervising physician as designated in E.8 Table 2. The signature should identify the author, date and time of entry in the health record. Signatures and co-signatures may be manual or electronic.

2. **Verbal Orders:** The use of verbal orders should be limited to those situations in which it is impossible or impractical for the prescriber to write the order or enter it into a computer. Verbal orders are not to be used for the convenience of the ordering practitioner. Such orders are authenticated (signed, timed and dated) by the practitioner responsible for the patient at the time of the next visit or within forty-eight (48) hours. Individuals authorized to accept and transcribe verbal
RULE 002: MEDICAL RECORDS

orders from a credentialed practitioner include: Registered Nurses, Certified Respiratory Therapy Technician and Registered Respiratory Therapist for respiratory therapy, speech/physical/occupational therapists and/or their designees for patient care orders pertaining to speech/physical/occupational therapy, pharmacist for medication orders, registered dietician or registry-eligible dietitian for nutrition related treatment and monitoring parameters, registered vascular technologists for non-invasive vascular studies, and diagnostic medical sonographer within their respective area of expertise; social workers may accept only discharge orders that are limited to durable medical equipment, chest x-rays, home nursing agency/support groups and home oxygen.

- Verbal orders for restraints shall comply with the current restraint policy.
- All practitioners will comply with the “read-back” rule contained in the Nursing Medication Administration Policy.

3. Abbreviations: Practitioners are encouraged to use the approved abbreviation list as developed by the MHP Osteopathic Principles Committee and approved by the Medical Executive Committee. In no case will abbreviations be used that have been identified as dangerous by the Medical Executive Committee.

4. Corrections/Erasures: At no time shall any part of the medical record be removed or rendered illegible. If corrections are necessary, the corrections shall be labeled as such, dated and signed by the person making the correction.

E. MEDICAL RECORDS RESPONSIBILITIES

1. Completion of the Medical History and Physical Examination:
   a) Individuals Authorized to Perform/Dictate: Only Medical Staff members, or individuals authorized by the Medical Staff will write or dictate medical histories and physical examinations (H&P's). See Table 1 below:

<table>
<thead>
<tr>
<th>H&amp;P Privileges</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/DO</td>
<td>Yes</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>Yes</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>Yes with MD/DO Co-Signature</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>Yes with MD/DO Co-Signature</td>
</tr>
<tr>
<td>Podiatrist+</td>
<td>Yes with restrictions, see below.</td>
</tr>
<tr>
<td>Oral Surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental Staff+</td>
<td>Yes with restrictions, see below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24-Hour H&amp;P Updates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MD/DO</td>
<td>Yes</td>
</tr>
<tr>
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<tr>
<td>Nurse Practitioner</td>
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</tbody>
</table>
**RULE 002: MEDICAL RECORDS**

<table>
<thead>
<tr>
<th>Physician Assistant</th>
<th>Yes with MD/DO Co-Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatrist+</td>
<td>Yes</td>
</tr>
<tr>
<td>Oral Surgeon</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental Staff+</td>
<td>Yes</td>
</tr>
</tbody>
</table>

+ Limited to procedure specific documentation as outlined in Section E.1.e.

b) **For all Inpatients and Any Outpatients Undergoing Surgery/Procedures with Moderate Sedation or Anesthesia Services:** A medical history and physical examination must be completed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery, to include the components referenced in E.1.d. The medical history and physical examination must also be updated prior to the procedure on the day of admission and after registration. This update note should document the patient’s general condition and any changes to the patient's condition since the date of the submitted history and physical. If office evaluation notes are utilized as the history and physical, they must contain all the required elements referenced below in a single organized document with the surgeon/procedural physician documenting the pre-procedure diagnosis, plan, with signature and date. The only exception to this rule is for OB/Maternity patients where an ACOG form presented from the physicians’ office suffices for the history and physical which must be updated at the time of admission.

c) **For Outpatient Surgery/Procedures without Moderate Sedation or Anesthesia Services:** Documentation components include the indication for the procedure and pre-procedural diagnosis. Appropriate documentation must be in the medical record prior to surgery or invasive procedure.

d) **Components of Medical History & Physical Examination:** All documents should have the following components included:

**History**
- Chief complaint
- Medications and Allergies
- Present illness
- Past medical history
- Social and personal history
- Family medical history
- Review of systems

**Physical**
- General condition
- Vital signs
- Examination
RULE 002: MEDICAL RECORDS

Diagnoses
Impression
Plan
e) Pre-Procedural Documentation by Non-MD/DO for Surgery/Procedures under Moderate Sedation/Anesthesia Services: If surgery is to be performed by other than an MD, DO, or appropriately credentialed oral surgeon, there must be a medical history and physical performed by a physician licensed in the State of Michigan, or designee with physician authentication (cosigned, timed, and dated) (See Section E.1.a Table 1). In addition, the operating/procedural individual must document an appropriate regional examination addressing the following elements:
- Description of the clinical history of the patient's problem;
- Description of what has been attempted in the past to address this problem;
- A record of the specialty specific regional examination;
- A pre-operative diagnosis;
- Proposed procedure.

f) Emergency Situations: In an emergency, when there is no time to record the complete history and physical examination, a progress or admission note describing a brief history and appropriate physical findings, the preoperative diagnosis, and the plan of care is recorded in the medical record before surgery. See the Medical Staff Bylaws for provisions concerning automatic suspension of privileges for failure to comply with this rule.

2. Omission of Surgical Records: A signed informed consent form must be present on the chart prior to pre-operative medications and/or induction of anesthesia. In the instance of extreme emergency, the judgment of the attending surgeon(s) shall take precedence.

3. Surgical Records - Emergency: In the absence of a signed informed consent form, a "witness phone call" will be acceptable.

4. Operative Notes: Operative notes shall be dictated or entered electronically immediately after surgery or within twenty-four (24) hours, and shall contain the name and hospital identification number of the patient, date and times of the surgery, name of the surgeon and assistants or other practitioners who performed surgical tasks, preoperative and postoperative diagnosis, name of the specific surgical procedure performed, complications if any, type of anesthesia administered, a description of techniques, findings, and tissues removed or altered, prosthetic devices, grafts, tissues, transplants, or devices implanted if any, estimated blood loss, and description of specific significant surgical tasks that were conducted by practitioners other than the primary surgeon. In addition, a written or electronically entered immediate post-operative progress note must be documented in the medical record immediately following the procedure, using an approved MHM template, and addressing the following elements: pre- and post-
RULE 002: MEDICAL RECORDS

operative diagnosis, name of surgeon and assistants, procedure performed and description of the procedure, findings, estimated blood loss, specimens removed, complications if any, and type of anesthesia administered.

5. **Anesthesia Record**: Anesthesia record to include: a written or electronic pre-procedure note on all patients undergoing spinal or general anesthesia to include anesthesia history and risk of anesthesia, written intra-operative summary of anesthesia services provided, and documentation of a post-anesthetic visit shall be recorded after the patient leaves the OR/Procedure Room or Recovery Room.

6. **Medical Record Entries and Authorization**: All entries made into the medical Record shall be dated, timed and authenticated by the originator. All health care team members involved with the care of the patient may make entries into the Medical Record. Health Care Team members are defined by the following staff/department categories: Medical Staff, Medical Students, including Intern, Residents and Externs, Physician Assistants, Nurse Practitioners, Midwives, Nursing, Nurses, Nursing Assistants, Pharmacists, Respiratory Therapy staff, Dietitians, Social Workers, Physical, Occupational, Rehabilitation, Speech, Recreational Therapists, Radiologists, Radiology Technicians, Ultrasound Technicians, Psychologists, Behavioral Health Providers, Mental Health Providers, Certified Registered Nurse Anesthetists, Pastoral Care Providers, Home Health Care Coordinators from outside contracted agencies, and continuing care community Agencies.

7. **Required Documents To Be Signed**: The following hospital documents shall be signed by the attending physician/interpreting physician:
   a) History and Physicals
   b) Operative Reports
   c) Consultations
   d) Discharge Summaries
   e) Any report requiring physician interpretation

8. **Countersignature/Documentation Requirements**: Portions of the medical record which must be co-signed are reflected in Table 2 below:

<table>
<thead>
<tr>
<th>STAFF TYPE</th>
<th>CO-SIGN REQUIRED BY THE ATTENDING PHYSICIANS</th>
<th>CO-SIGN REQUIRED BY THE ATTENDING PHYSICIANS</th>
<th>CO-SIGN REQUIRED BY THE ATTENDING PHYSICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DICTATED REPORTS</td>
<td>ORDERS</td>
<td>PROGRESS NOTES</td>
</tr>
<tr>
<td>Residents</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Interns</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital Care</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital Care</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Certified Nurse Midwives</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
RULE 002: MEDICAL RECORDS

<table>
<thead>
<tr>
<th>Registered Nurses++</th>
<th>Yes</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Students</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacists (For Med orders)</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Individuals Authorized to Accept and Transcribe Verbal Orders from a Credentialed Practitioner – See D.2</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

++ RNs may dictate discharge summaries only.

9. Delinquent Records: All patient medical records shall be completed within thirty (30) days after the date of discharge of the patient. The Health Information Management Department shall notify a practitioner by written communication within seven (7) days of patient discharge as a reminder that charts are available for completion. Those practitioners who have incomplete charts fourteen (14) days from the date that charts are available will be sent a second written communication stating they have charts to complete within thirty (30) days of discharge. If medical records are not complete within the thirty (30) day time period, the respective Department Chair (or designee) will contact the practitioner to address their delinquent status and the need for immediate resolution. If records remain outstanding fourteen (14) days after this intervention, an invitation will be sent to the delinquent provider to attend the next Medical Executive Committee meeting to explain the barriers that keep them from completing their medical records in a timely manner. Failure by the practitioner to attend the meeting will result in disciplinary action at the discretion of the Medical Executive Committee.

10. Filing of Medical Records: No medical record shall be filed until it is complete, except on order of the Medical Records Committee, when it is determined that the information is unobtainable due to death, incapacitation or resignation of a staff member. A system of identification and filing to ensure the rapid location of a patient's record shall be maintained. Records should be indexed according to disease, operation and the physician. Medical records should be coded according to the most current system.

11. Ownership/Safekeeping: The medical record is the property of MHM and shall not be removed except when required by law. In case of a readmission of a patient to the hospital, all previous records shall be available for the use of the attending physicians. This shall apply to all patients, whether they are attended by the same physician or by another.

12. Access to Records: Credentialed MHM practitioners shall have access to patient medical records only as follows:
   a) For a current MHM patient, credentialed MHM practitioners currently treating or caring for the patient may have access to all of the patient’s medical records;
   b) For former patients credentialed MHM practitioners who previously
RULE 002: MEDICAL RECORDS

cared for or treated the patient at an MHM facility, either as an inpatient or outpatient, may have access to the patient’s medical records, but only those medical records which pertain to the patient’s care during a hospitalization or outpatient treatment when the patient was attended by the practitioner; and

c) Practitioners serving on a Medical Staff or MHM Committee or serving as a Medical Staff Officer shall have access to MHM patient medical records as necessary to perform and complete their assigned duties and functions. Access to records for education and research will follow the policies of the Release of Information of the Clinical Information Services Department.

Except as specifically provided in the preceding three (3) subparagraphs, practitioners shall not have access to patient medical records unless access thereto has been legally authorized in writing by the patient or the patient’s duly authorized legal representative.

All practitioners shall maintain the confidentiality of all patient records and shall only disclose the content thereof as permitted by law. The provisions of this section shall apply to all MHM patient medical records.

F. MEDICAL RECORD CONTENT GUIDELINES FOR AMBULATORY CLINICS/SITES

Medical record content guidelines relative to MHM affiliated Ambulatory Clinics and/or Ambulatory Sites where care is provided by licensed independent practitioners are addressed in Rule 002 - Appendix A.
**RULE 002: MEDICAL RECORDS**

W/HMS/MHP MS Rules-Regs/2016/Rule 002 Medical Records no Attachment Final 9-29-16.doc

Attachment: Appendix A, Ambulatory Medical Record Content