UNIVERSITY of VIRGINIA HEALTH SYSTEM

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0094

A. SUBJECT: Documentation of Patient Care (Electronic Medical Record)

B. EFFECTIVE DATE: April 1, 2012 (R)

C. POLICY:

The University of Virginia Medical Center shall maintain a complete, accurate, reliable, and fully integrated electronic medical record (EMR) for every individual who is evaluated, treated, or receives services at the Medical Center, with the EMR being the exclusive modality for documentation of patient care. Use of other modes of documentation (i.e., paper) shall be minimal and shall only occur during announced designated system downtime, or where such use has been pre-approved by the Health Information Management Subcommittee (HIMS).[1]

The EMR is shared by all providers and staff across the continuum of care settings. In order to realize the quality benefits of the EMR, and to aid provider utilization of the shared record, it is essential that all users observe a common set of practice principles when documenting patient care using the EMR.

Ownership of information contained within medical records belongs not to the providers, but to the patients. All Medical Center employees and all healthcare providers having a professional relationship to a Medical Center patient, or who facilitate communication or interaction between providers and patients, shall be responsible for accurate and timely documentation in the patient's EMR, in accordance with the procedures set forth herein and in other relevant Medical Center policies. The history and physical examination (H&P) is the responsibility of the attending physician. It may be completed by an attending physician, nurse practitioner, physician assistant or GME trainee approved by the Medical Center to do so. Data collected by nurses, pharmacists, social workers and therapists and entered in the record may be included in the history.

This policy sets forth principles to foster a common understanding as to how the EMR will be used at the University of Virginia Medical Center to document within the medical record.

All persons, regardless of employer, having a professional relationship for patient care at the Medical Center, or who facilitate communication or interaction between providers and patients, shall:

1. Use the EMR as the primary mode of documentation of the core content of patient care as more fully described in Section D.1 (Documentation Defined) below. As noted above, use of other modes of documentation (i.e., paper) shall be minimal and shall only occur during announced

[1] Those areas whose use of paper or other modes of documentation has been pre-approved by HIMS shall be required to follow the processes and procedures contained in Attachment A. Attachments B and C apply to both electronic and non-electronic modes of documentation.

designated system downtime, or where such use has been pre-approved by the Health Information Management Subcommittee (HIMS);

2. Use the EMR to communicate with other healthcare professionals regarding patient care issues in accordance with this and other relevant Medical Center policies and procedures; see Medical Center Policy No. 0163, "Access to Electronic Medical Records and Institutional Computer Systems", Medical Center Policy No. 0193, "Electronic Mail {E-mail}") and Medical Center Policy No. 0202, "Internet and Intranet Access/Usage";

3. Use secure electronic modalities (such as MyChart™) to communicate with patients about patient care issues;

4. Accomplish electronically the timely charge capture of all professional and facility services; and

5. Participate in and support electronic quality reporting initiatives.

Health System Technology Services (HSTS) (formerly Health System Computing Services, HSCS) shall grant security access to the EMR only to those individuals who demonstrate competence in its use, in accordance with standards and requirements established by HSTS. HSTS shall conduct random audits to ensure ongoing use of, and competence in, the EMR by all individuals having security access, consistent with this and other relevant Medical Center policies. The Corporate Compliance and Privacy Office shall conduct ongoing random audits to ensure appropriate access to the EMR.

D. PROCEDURES:

1. DOCUMENTATION IN THE EMR; DEFINITION AND CONTENT:

a. *Core Content*. Documentation in the EMR shall include, but shall not be limited to, the following information:

i. Patient identification information
- Name, address, birth date, sex, next of kin, medical record number, legal status (behavioral health patients), name of any healthcare agent
- Patient's language and communication needs

ii. Current medication and dosages

iii. Known medication and food allergies and adverse drug reactions

iv. Advance Directive, including healthcare agent, as appropriate (patients 18 years of age and older)

v. Informed consent as required by the place of service or nature of procedure

vi. Documentation of patient encounters:

- Reason for care (chief complaint, reason for admission)
- The patient's initial diagnosis, diagnostic impression(s)
- Other medical conditions (problem list, health screening or assessment)
- Relevant patient history

- Physical examination or mental status examination
- Plan of care that includes treatment goals and revisions to the plan
- Orders for tests, medications, procedures, consultations, restraints
- Incidental encounter, which is defined as patient contact that cannot be connected to a clinical encounter or documented via another appropriate means

vii. Documentation of care provided

- History and Physical (See Attachment B)
- Test results
- Medication administration including the strength, dose and route as well as administration devices used and rate of administration
- Medication reconciliation, which is to be performed upon admission, transfer, and discharge
- Procedure results
- Brief operative and full operative notes
- Bedside/ambulatory procedures
- Consultation results
- Progress notes/flow sheets
- Documentation of restraint use
- Communications with patient/patient's family members and healthcare providers, as appropriate
- Education
- Follow-up documentation for on-going ambulatory care
- At discharge of inpatient stay:
    - Final diagnosis and associated problems and procedures
    - Discharge instructions
    - Discharge summary including medications
    - Time and reason that patient left against medical advice (if applicable)
    - Death note (as indicated)

b. General Documentation Guidelines:

i. *Authentication*: All clinical entries in a patient's medical record shall be accurately dated and timed, and must be authenticated by (i) electronic signature or (ii) written signature and professional title, printed name or PIC number, and professional title (e.g., MD, RN). Practitioners requesting use of an electronic signature are required to sign and submit an Electronic Access Agreement to Health System Technology Services prior to initial use.

ii. *Entries by healthcare students* in a patient's medical record shall be supervised by the responsible party. See Attachment C to this Policy for additional requirements regarding medical student documentation.

iii. *Abbreviations:* Abbreviations listed on the "prohibited abbreviations list" shall not be used in the medical record. A list of the prohibited abbreviations is available via the intranet at https://www.healthsystem.virginia.edu/intranet/HIS/.

iv. *Late Entries and Addendum*: If a "late entry" or "addendum" is required, electronically enter, write or dictate "late entry" or "addendum" and the actual date and time of entry with signature.

v. *Corrections:* Instructions on chart corrections are available via the intranet at https://www.healthsystem.virginia.edu/intranet/HIS/.

vi. *Documentation Standards*: All credentialed and/or licensed independent practitioners (LIP)[2] and all other healthcare discipline providers shall document according to discipline.

vii. *Documentation of Record Reviews for Requested Review of Care Opinions*: Upon request of a patient or a surrogate decision-maker acting on the patient's behalf, a physician member of the Medical Center's Clinical Staff, a Medical Center Graduate Medical Education (GME) Trainee (Resident) or other Medical Center LIP may review a patient's medical record for purposes of offering an opinion on the care that has been provided. The reviewing physician or practitioner shall document such requested review (name of requestor) in the patient's medical record. The reviewing LIP shall not enter orders for the care of the patient.

viii. *Delinquent Records:* All medical records are considered to be delinquent if not completed within 30 days of the discharge/visit. Delinquency statistics, by physician, are provided to the Credentialing Office for consideration in medical staff reappointment. Refer to the attachment "*Specific Documentation Requirements by Professional Healthcare Providers"* for delinquent record time standards on specific documents.

ix. Operative, procedural, consult and inpatient progress notes must be signed by the attending physician; signing should occur within two (2) calendar days of entry.

x. *Completion and Authentication Responsibility*: Attending physicians may delegate the completion/dictation of history and physicals, operative notes and discharge summaries to a GME Trainee (Resident), Nurse Practitioner or Physician Assistant; however the Attending Physician is ultimately responsible for completion and signature of these documents.

SIGNATURE:

Robert Gibson
Robert S. Gibson, M.D., President Clinical Staff

R. Edward Howell
R. Edward Howell, CEO, UVA Medical Center

DATE: 3/21/12

[2] For the purposes of this policy, licensed independent practitioner (LIP) includes physicians, nurse practitioners, and physicians' assistants.

(SUBJECT: Documentation of Patient Care (Electronic Medical Record))

Medical Center Policy No. 0094 (R)
Approved November 1985
Revised September 1993, March 2003, April 2004, November 2004, December 2006, December 2007, June 2008, June 2009, June 2010, February 2011, September 2011, March 2012
Reviewed May 1996, October 1999
Approved by Quality Committee and Health Information Management Sub-committee
Approved by Clinical Staff Executive Committee

Attachment A: General Use Requirements for Documentation of the Medical Record in the Non-Electronic Environment (with prior permission of HIMS)
Attachment B: Specific Documentation Requirements by Professional Healthcare Providers (applies to use in both electronic and non-electronic environments)
Attachment C: Additional Requirements for Documentation by Medical Students (applies to use in both electronic and non-electronic environments)

ATTACHMENT A

GENERAL USE REQUIREMENTS FOR DOCUMENTATION OF THE MEDICAL RECORD IN THE NON-ELECTRONIC ENVIRONMENT (WITH PRIOR PERMISSION OF HIMS)

All general documentation requirements under this policy MCP0094 as set forth in Sections D. 1 (a and b), as well as Attachments B and C, apply to any and all records created and maintained in the non-electronic environment. Additionally:

1. **Forms**: All Forms used for documentation in the medical record shall have been previously approved by the HIM Subcommittee. Documentation contained on an unapproved form will be returned to the sender in order to be re-documented on an approved form. The only exceptions are outside facility and legal documentation. The website defining the process to approve or revise a clinical form is http://www.healthsystem.virginia.edu/pub/his/intranet/how-to-create-or-revise-a-form-at-uva-health.doc

2. **Legibility**: All entries shall be made in black ink, on white paper, and legible.

3. **Corrections to handwritten entries** shall have a single line drawn through the erroneous entry, the date of the correction, initials of person making the correction, and reason for correction. The correct entry shall be made in chronological order and indicate the specific entry to be replaced.

4. **Documentation** for scanning will be retrieved by HIS from the inpatient unit upon discharge and available in the EMR within 12 hours of receipt. Ambulatory and outpatient procedure area documentation will be made available to and retrieved by HIS within 30 days post visit and available in the EMR within 2-4 days post receipt.

5. **EMR Downtime:** In the event of an EMR downtime, approved clinical forms shall be utilized. Medications, allergies, and problems (or diagnoses) obtained in the ambulatory setting shall be entered into EPIC upon availability. The EMR downtime procedure is available via the intranet at http://www.healthsystem.virginia.edu/ell/search?SearchableText=EMR+downtime.

Attachment B: Medical Center Policy No. 0094
Specific Documentation Requirements
(applies to use in both electronic and non-electronic environments)

Element	Authenticating Party	Inpatient	Short-stay	Ambulatory Care & Emergency Department
H&P * Must include: • Chief complaint • Relevant Past Medical History • Details of present illness • Social history • Allergies and current medications • Family history • Review of Systems (ROS) • Physical examination pertinent to diagnosis • Pertinent normal and abnormal findings • Conclusion, planned course of action including discharge planning	LIP Social Workers in Psychiatric Medicine may complete the social history. Note: The history may be documented by any party, including the patient.	Complete within 24 hours of admission to an inpatient unit or 30 days prior to admission and before surgery or procedure requiring anesthesia or titrated (moderate or deep) sedation. An H&P completed within 30 days prior to admission is acceptable but must be updated at admission. In addition, prior to a planned procedure, the H&P must be updated with specific reference to (1) interval changes, (2) the airway, (3) cardiac and respiratory status, (4) medications, (5) allergies and (6) appropriate physical examination.	Complete within 12 hours of admission or 30 days prior to admission and before surgery or procedure requiring anesthesia or titrated (moderate or deep) sedation. An H&P completed within 30 days prior to admission is acceptable but must be updated at admission. In addition, prior to a planned procedure, the H&P must be updated with specific reference to (1) interval changes, (2) the airway, (3) cardiac and respiratory status, (4) medications, (5) allergies and (6) appropriate physical examination.	Complete pertinent H&P at the time of the clinic or ED visit and before surgery or procedure requiring anesthesia or titrated (moderate or deep) sedation. In addition, prior to a planned procedure, the H&P must be updated with specific reference to (1) interval changes, (2) the airway, (3) cardiac and respiratory status, (4) medications, (5) allergies and (6) appropriate physical examination.
Focused H&P Must include: • Chief Complaint • Relevant past medical history • Allergies and current medications • Physical examination pertinent to diagnosis • Pertinent normal and abnormal	LIP	Complete prior to and not longer than 30 days before a surgery/procedure. A copy of an H&P completed within 30 days prior to planned surgery/procedure is acceptable but always must be updated with specific reference to (1) interval changes, (2) the airway, (3) cardiac and respiratory status, (4) medications, (5) allergies and (6) appropriate physical examination.		Complete at the time of the clinic visit in regards to specialty Clinics, Emergency Dept., before surgery/procedure and visits subsequent to the complete assessment in primary care clinics.

findings • Conclusion, planned course of action				In addition, prior to a planned procedure, the H&P must be updated with specific reference to (1) interval changes, (2) the airway, (3) cardiac and respiratory status, (4) medications, (5) allergies and (6) appropriate physical examination.
Re-assessment Must include: • Details/changes to medical history • Focused physical examination • Pertinent normal and abnormal findings • Conclusion, planned course of action • Change in status (e.g. Code 12)	LIP	Every 24 hours	Every 12 hours	Complete at the time of the ED visit and as indicated as the patient's condition changes.

*An H&P is not required for the following:

- Certain routine minor procedures, such as venipuncture, peripheral IV line placement, or insertion of a NG tube or indwelling urinary catheter.
- Established ambulatory visits where the sole purpose of the visit is for medication administration, medication changes, or counseling (e.g. to discuss treatment options).
- Cardiology echo or stress tests

For procedures that do not include titrated sedation (moderate or deep) or anesthesia other than topical, local or regional block (e.g. liver biopsy or paracentesis that involves the puncture or incision of the skin or insertion of an instrument or foreign material into the body, excluding routine minor procedures as defined above), documentation must include an examination of the body area(s), relevant to the safe performance of the procedure, as well as a review of pertinent laboratory tests and other diagnostic results.

Element	Authenticating Party	Inpatient	Short-stay	Ambulatory Care

NURSING ASSESSMENT			
Admission Assessment Nursing physical assessment • Critical Care, Intermediate Care, & L&D • Adult and Pediatric Acute Care, & Obstetrics • Behavioral Health **Ambulatory-Care Assessment** • Ambulatory care • Procedure Area • Emergency Department	RN	**Assessment** Initial physical and risk assessment completed within 8 hours of admission (full systems (head to toe) including skin, suicide and fall risk). **Re-Assessment** Q12 hours or more frequently as indicated.	**Assessment** **Ambulatory Care Procedure Area** At presentation where nursing care provided **Emergency Dept** At patient presentation **Re-Assessment** **Ambulatory Care Procedure area** As needed **Emergency Dept** Every 4 hrs or more frequently as indicated.
SCREENING & PLANNING			
Admission Screening & Discharge Planning Must include: • Advance Directives Screening • Nutritional Screening, • Substance Use Screening • Learning Screening • Safety Screening • Pain Screening • Functional Screening • Psycho-social Screening • DME/Home Health Referral	RN DME &/or Home Health – Social Work (Inpatient/Short Stay) or Appropriate Discipline (Outpatient)	Initiated within 8 hours of admission and completed (with all elements addressed) within 24 hours. Screening referrals must be addressed by the discipline within 48 hours. Patient choice must be documented when a DME and/or Home Health Referral is made.	Patient choice must be documented when a DME and/or Home Health Referral is made.

Element	Authenticating Party	Inpatient	Short-stay	Ambulatory Care
DISCHARGE SUMMARIES				

Discharge Summary Must include: • Admission diagnosis • Discharge diagnosis • Hospital course/summarization • Reason for admission • Significant findings • Procedures performed • Treatment given • Disposition of patient upon discharge • Instructions given for activity, medications, diet and follow-up instructions	LIP	Dictated within 24 hours post discharge and signed within 7 days post discharge. (A final discharge progress note may be substituted in cases of healthy newborns). Delinquent if not dictated 5 days post discharge and not signed 30 days post discharge.	NA
Death Summary Must include Discharge Summary elements in addition to: • Exact time and date of death pronouncement • Probable cause of death • Party notifying next of kin • Permission for autopsy obtained	LIP	Dictated within 24 hours post discharge and signed within 7 days post discharge. Delinquent if not dictated 5 days post discharge and not signed 30 days post discharge.	NA
OPERATIVE REPORTS & PROCEDURE NOTES			
Brief Operative Note Must include: • Procedure name • Findings • Pre-operative diagnosis • Post-operative diagnosis • Specimen(s) • Major events • Complications • Estimated blood loss • Drains • Names of surgeons/assistants (including authorizing	LIP	A brief operative note is required immediately after surgery/procedure if the detailed operative report will be dictated (including dictation within Epic requiring transcription). The detailed operative report must be dictated the day of surgery or procedure. In cases where the detailed operative note is completed in Epic, a brief operative note is not required, *provided* the detailed operative note is completed and signed by the author before the patient leaves the OR/procedure room *and* is immediately visible to all other Epic users. Notes	

physician) • Date and time it was written **Detailed Operative Report/Procedure Report** Must include above contents in addition to: • Detailed account of the findings at surgery • Detailed account of the surgical technique		that are pended or shared or require any transcription, as opposed to completed and signed, are not available for all to see. Detailed operative report is delinquent if not dictated within 24 hours post surgery and not signed within 30 days post surgery. Attending Physician may be fined if the operative report or procedure report is not dictated within 24 hours of the date of surgery/procedure.		
Element	**Authenticating Party**	**Inpatient**	**Short-stay**	**Ambulatory Care**
OUTPATIENT CLINIC DOCUMENTATION				
Must include: • Chief complaint • Problems • History of present illness • Medications • Allergies • Past/Family/Social history • Review of systems • Physical exam • Procedures • Assessment • Plan • Education and follow-up	LIP Chief complaint, history and review of systems, medications, and allergies. Information may be gathered by anyone, including the patient. The LIP must review and acknowledge in order to use these elements for billing.	NA	NA	Complete within 30 days post visit.
OUTPATIENT SCREENING				
Based on chief complaint (reason for visit), may include: • Medication use • Medical allergies	LIP	NA	NA	**Medication Use & Allergies** Reviewed and updated at each visit

• Pain screening • Nutritional screening • Functional screening • Abuse and Neglect				**Pain Screening** Based on reason for visit **Nutrition & Functional Screening** Based on reason for visit **Abuse & Neglect** Based on reason for visit
PLAN OF CARE				
	All Disciplines	Initiated within 8 hours of admission and completed by RN upon discharge. Discharge/Care planning is documented and includes providing a choice of agencies for SNF, Home Health, and DME agencies as well as written discharge instruction.		NA
CONSULTATIONS				
	All Disciplines	**Emergent Need** Addressed within 2 hours **Non Emergent Need** Addressed within 24 hours from time ordered **Screening Referrals** Addressed within 48 hours	Addressed within 12 hours from time ordered.	**Emergent Need** Addressed within 2 hours **Non Emergent Need** As appointments are available
HOSPITAL EDUCATION PROGRAM DOCUMENTATION (HEP)				

Education encounter/progress note Learning clinic summary Learning evaluation note Education discharge note Communication to school Incidental encounter (HEP). *As appropriate, HEP employees will document all evaluations, significant clinical encounters, consultations, assessments and contact with schools in the medical record. HEP will document incidental encounters (telephone contact, pre-clinic contact and school visits) as appropriate. HEP will document initial encounter for inpatients in the progress note section according to the MOU with the Medical Center. Attendance at HEP inpatient or outpatient programs do not need to be documented by HEP unless encounter warrants communication with multidisciplinary team.	HEP employees	Complete within 24 hours of visit	NA	Complete within 30 days post visit

Attachment C: Medical Center Policy No. 0094
Additional Requirements for Documentation by Medical Students
(applies to use in both electronic and non-electronic environments)

Students	Element	Requirement	Supervisor Responsibility
Medical students	Procedures	Medical students may document procedures only if the teaching physician is present for the entire procedure.	The teaching physician's documentation must identify the procedure performed and document his/her presence and supervision of the entire procedure. The teaching physician may refer to the medical student's documentation for further details. An example of such teaching physician documentation includes: "Present and supervised the entire (procedure name). See medical student's note for details. (Teaching physician name).
Medical students	Review of Systems and Past/Family History and Social History component of evaluation/management service.	Medical students may complete and document.	Teaching physician may use medical student documentation to support a billable service if the documentation is reviewed and either signed by or referred to in the teaching physician's documentation.
Medical students	History of Present Illness, Exam and Medical Decision-making components of evaluation/management service.	Medical students may perform or obtain these components. However, the documentation will not support nor be used for billing purposes.	Teaching physician must perform/obtain and document these components to support a billable service.