Mental Health Emergency Center		
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Scope: ☒ Mental Health Emergency Center (MHEC)		

HOSPITAL MEDICAL RECORD CONTENT POLICY

POLICY STATEMENT

It is the policy of the Medical Staff to maintain complete and accurate medical records. This policy will define the required elements and their content for the medical record according to regulatory requirements and best practice. The attending Practitioner and other Staff Members, as applicable, shall be responsible for the complete and legible medical record for each Medical Center patient. Each medical record shall include the information set forth below and any additional required documentation as may be described in Departmental policies. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws. With respect to Medical Record requirements, please also reference the Advocate Aurora Health, Inc. (AAH) Medical Record Documentation Policy.

1. DEFINITIONS

"Medical Records" includes all written documents, computerized electronic information, radiology film and scans, laboratory reports and pathology slides, videos, audio recordings, and other forms of information regarding the condition of a patient.[1]

2. GENERAL REQUIREMENTS

2.1 Electronic Form.

Whenever possible, Staff Members and other authorized individuals must utilize Aurora's electronic health record systems to document all patient care and patient care related activities. Using down time forms or paper forms is permitted only when the electronic health record system is down and not able to support patient care. If paper documentation is required due to down time or other event, every page included in a medical record must be clearly labeled with

[1] 42 CFR § 482.24 (Interpretive Guidelines).

the patient's complete name and medical record number. All handwritten entries must be made with a pen (pencils and felt tip pens are not permitted). All paper documentation created must be scanned into the electronic health record by the HIM department.

2.2 Authorized Entries.

Only those individuals authorized by the Medical Center may make entries into a patient's medical record and must do so only through the Medical Center's password-protected electronic system, or on Medical Center-approved medical record forms.

2.3 Legibility

All entries in the medical record must be legible. Orders, progress notes, nursing notes, or other entries in the medical record that are not legible may be misread or misinterpreted and may lead to medical errors or other adverse patient events.

2.4 Date, Time, Authentication and Co-Signature[2]

(a) Date, Time, Authentication. All medical record entries must be dated, timed (using military time), and authenticated (by written signature, identifiable initials, computer key, or other code) by the individual who made the entry. This includes the Medical Staff Members involved in the cases and any employed Advanced Practice Clinician Staff Members, as well as students enrolled in an approved training program, contracted personnel and pre-hospital health care providers such as paramedics and emergency medical technicians as allowed by the Medical Center. All entries must be made as soon as possible after an event or observation is made. An entry may not be made in advance, and it is not acceptable to pre-date or back-date a medical record entry (see Sections 2.5 and 2.8 below regarding late entries and corrections). If it is necessary to summarize events that occurred over a period of time (such as an entire shift), the entry should indicate the actual time the entry was made with the narrative documentation identifying the time certain events occurred.

(b) Co-Signature. In certain circumstances, medical record entries must be co-signed by a Physician Medical Staff Member in accordance with AAH's Hospital Co-Signature Requirements Chart. The co-signing Physician accepts responsibility for the content of the medical record entry.

2.5 Late Entries

Refer to the AAH Medical Record Documentation Policy.

2.6 Completeness.

All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to: (a) identify the patient; (b) support the diagnosis/condition; (c) justify the care, treatment, and services provided; (d) document the course and results of care, treatment, and services; and (e) promote continuity of care among providers.[3] All medical

[2] 42 CFR § 482.24(c)(1).
[3] 42 CFR § 482.24(c)(1).

records must be completed within the applicable time frames provided on Exhibit A, attached to this Policy.[4] Pursuant to the Medical Staff Bylaws, sanctions for incomplete documentation may begin earlier than the timelines provided in Exhibit A to ensure such timelines are met.

2.7 Symbols and Abbreviations.

Use of abbreviations in medical record documentation can lead to miscommunication and potential errors in care, and therefore should be avoided when possible. Refer to AAH's Unacceptable Abbreviations Policy for a list of unacceptable abbreviations, acronyms, symbols and dose designations. Such list is available on the Aurora intranet site, at each nursing station, and the Health Information Services and pharmacy departments, along with a list of approved abbreviations, symbols and titles. If an unacceptable abbreviation is contained in the Staff Member order/note, the caregiver shall contact the Staff Member for clarification before carrying out the order.[5] The use of abbreviations when documenting the diagnosis is not allowed.

2.8 Correction of Errors.

(a) Correcting Electronic Errors. When an error needs to be corrected in or a change needs to be made to an electronic medical record entry, the correction should be made through Electronic Health Record. Whenever possible, the individual who authored the original entry must make the correction. If an individual other than the original author will make the correction, the author of the correction should communicate the correction to the original author as appropriate. Such corrections shall comply with AAH's Medical Record Corrections in Epic Electronic Health Record Policy.

(b) Correcting Handwritten Errors. When an error needs to be corrected in or a change needs to be made to a handwritten medical record entry, the following procedures must be followed:

i. Caregivers may **NOT OBLITERATE OR OTHERWISE ALTER THE ORIGINAL ENTRY** by blacking out with marker, using white out, writing over an entry, or otherwise obscuring the original text of the entry.

ii. Caregivers should draw a line through entry (thin pen line). Make sure that the inaccurate information is still legible.

iii. Caregivers must initial and date the entry.

iv. Caregivers must state the reason for the error (i.e., in the margin or above the note if room); and

v. Caregivers must document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available

[4] 42 CFR §§ 482.24(b) and 482.24(c)(2)(viii); Wis. Admin. Code DHS § 124.14(3)(c)3 (2009).
[5] Wis. Admin. Code DHS § 124.14(5)(b) (2009).

line/space documenting the current date and time and referring back to the incorrect entry.

(c) Alterations/Corrections Requested by the Patient. Refer to the Patient Information Change Requests Procedure (Aurora Compliance and Integrity/HIPAA/Privacy Information) for guidance regarding the corrections or addendums to a medical record requested by a patient or a patient's representative.

2.9 Use of Rubber Stamps. The use of a rubber signature stamps is prohibited.

3. MEDICAL RECORD CONTENT

Each medical record should contain at least the following based on services provided:

- General Requirements (3.1)
- Demographic/Identification Information (3.2)
- Advance Directives (3.3)
- Allergies (3.4)
- Emergency Department Record (3.5)
- Medications (3.6)
- Admission Order and Note (3.7)
- Progress Notes (3.8)
- Practitioner Orders (3.9)
- Diagnostic Testing and Results (3.10)
- Consultation Reports (3.11)
- Informed Consent or Refusal (3.12)
- History and Physical Examinations (3.13)
- Psychiatric Evaluation (3.14)
- Communications and Patient-Generated Information (3.15)
- Electrocardiographic Strips and Reports (3.16)
- Restraints and Seclusion (3.17)
- Adverse Events (3.18)
- Final Diagnosis and Discharge Summary (3.19)
- Ongoing Ambulatory Care Services (3.20)

3.1 General Requirements.

The medical record must contain information such as notes, documentation, records, reports, recordings, images, scans, films, test results, and assessments to: (a) justify admission; (b) justify continued hospitalization; (c) support the diagnosis; (d) describe the patient's progress; and (e) describe the patient's response to medications and services. In addition, the medical record must contain complete information/documentation regarding evaluations, interventions, care provided, services, care plans, discharge plans, and the patient's response to those activities.

3.2 Demographic / Identification Information

The medical record must contain the patient's: (a) name, address, date of birth; (b) gender, (c) language and communication needs, (d) authorized representative, and (e) legal status (if the patient is incapacitated or receiving behavioral health care services). If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative must be documented in the medical record.

3.3 Advance Directives

The medical record must contain copies of any advance directives as specified in the AAH Advance Directives Policy.

3.4 Allergies.
The medical record must identify the existence of any allergies to food, medications, latex, or other substances.

3.5 Emergency Department Record.
The Emergency Department Record must be completed within forty-eight (48) hours of the patient's discharge from the Emergency Department and must include:

(a) Time and means of arrival

(b) Any emergency care, treatment and service provided to the patient before his/her arrival at the Medical Center (if available)

(c) Time of physician involvement or notification

(d) Administration of treatment (including medications)

(e) Discharge or transfer from the emergency department (transfers to another acute health care facility must include documentation for Patient Transfers found in the Medical Center's EMTALA Policy)

(f) Conclusions at the termination of the emergency care to include:

i. Final disposition
ii. Patient condition
iii. Instructions/follow up care
iv. Any departure against medical advice

(g) Family history and social history as indicated by nature of presenting problem

(h) Past medical and surgical history as indicated by nature of presenting problem

(i) Evidence of known Advanced Directives as indicated by presenting problem

(j) Allergies (food, medication, latex, other)

(k) Medications as noted in Section 3.6 below

3.6 Medications.
The medical record must include information regarding the strength, dose, rate of administration, route, access site, administration device (if any), and unfavorable reactions, for all medications: (i) used by the patient prior to arrival; (ii) ordered, prescribed or administered after the patient's arrival; and (iii) dispensed or prescribed on discharge. Refer to the Medical Staff's Provider Orders Policy for information regarding medication orders. Refer to AAH's Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

3.7 Admission Order and Note.

For each Medical Center inpatient, the medical record must contain an admission order and note. Refer to the Medical Staff's Admission, Transfer and Discharge Policy for specific documentation requirements.

3.8 Progress Notes.[6]

(a) Care, Treatment and Services. The medical record must contain progress notes which provide a chronological description of the course and results of care, treatment, and services provided, the patient's progress, and any revisions to the plan of care. Such progress notes shall be entered at the time of observation and shall be sufficient to permit continuity of care and transfer of the patient. Whenever possible, each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests, procedures and treatments. Final responsibility for an accurate description of the patient's condition and progress rests with the attending Practitioner. The attending Practitioner (or his/her designee) shall enter a progress note at least daily for acutely and critically ill patients and patients for whom there is difficulty in diagnosis or management of the clinical problem. If a progress note is entered by an Advanced Practice Professional, refer to AAH's Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

(b) Need for Continued Hospitalization The medical records must contain documentation describing the need for continued hospitalization after specific periods of stay (as identified by the utilization review plan and/or criteria developed for concurrent review). Such documentation shall contain an adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient). This documentation may also contain the estimated period of time the patient shall need to remain in the Medical Center; and plans for post-hospital care.

(c) Copy and Paste. Practitioners may copy and paste into the medical record only information needed to support clinical decisions or illustrate direct impact on care. Succinct notes are more readable than verbose, lengthy notes. Practitioners shall not copy and paste between two different patients' records and shall not copy documentation from another provider without clearly identifying the original author.

3.9 Practitioner Orders.
The medical record must contain written and verbal orders as specified in the Medical Staff's Provider Orders Policy.

3.10 Diagnostic Testing and Results.
The medical record must contain all orders for and results and reports from diagnostic and therapeutic tests and procedures, including without limitation, all clinical laboratory, imaging, and other diagnostics.[7] Interpretations of imaging reports shall be written or dictated and shall

[6] 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective July 10, 2015); Wis. Admin. Code DHS § 124.14(3)(a)12 (2009).
[7] 42 CFR § 482.24(c)(4)(vi) (Interpretive Guidelines, effective July 10, 2015); Wis. Admin. Code DHS §§ 124.14(3)(a)6-7 and 124.18 (1)(e)1 (2009).

be signed by a qualified Physician or another individual authorized by the Medical Staff to interpret the image.[8] Refer to the Medical Staff's Provider Orders Policy for information regarding orders of diagnostic services. Refer to AAH's Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

3.11 Consultation Reports.[9]

The medical record must contain consultation reports from each consulting practitioner, including a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record, and the consulting practitioner's recommendations. Refer to AAH's Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

3.12 Informed Consent or Refusal.

The medical record must contain documentation of properly executed informed consent forms for procedures and treatments (including documentation of circumstances when a patient leaves the Medical Center against medical advice) in accordance with AAH's Informed Consent/Informed Refusal Policy.[10]

3.13 History and Physical Examinations.

(a) Purpose. The purpose of a medical history and physical examination (H&P) is to (1) document the dialogue with the patient or patient representative, (2) document the physician's evaluation of the patient, and (3) determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient.[11]

(b) Providers that may perform. Physicians, nurse practitioners, physician assistants, doctors of podiatric medicine, and certified nurse midwives may perform History and Physical Examinations (H&P) in accordance with the Medical Staff Bylaws and the Policies Governing Medical Practices.

(c) Inpatients. The Staff Member who is responsible for the care and treatment of the patient during the patient's inpatient stay is responsible for ensuring that an H&P is performed, documented, and authenticated for each Medical Center inpatient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.[12]

(d) Updates to H&P. An updated examination of the patient, including any changes in the patient's condition, be completed and documented within twenty-four (24) hours after

[8] Wis. Admin. Code DHS § 124.18(1)(e)3 (2009).
[9] 42 CFR § 482.24(c)(4)(iii) (Interpretive Guidelines, effective July 10, 2015); Wis. Admin. Code DHS § 124.14(3)(a)8 (2009).
[10] 42 CFR § 482.24(c)(4)(v).
[11] 42 CFR § 482.22(c)(5)(i).
[12] 42 CFR § 482.22(c)(5)(i); 42 CFR § 482.24(c)(2); Wis. Admin. Code DHS § 124.14(3)(a)9 (2009).

admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration.

(e) Emergency Department Notes. Practitioners may not use the emergency department notes the serve as the H&P for a patient.

(f) H&P Requirements. The requirements for inpatient H&Ps are as follows:

i. Basic Inpatient H&P (for patients who are not scheduled for an operative or invasive procedure) shall include:

- Reason for admission/chief complaint
- History of present illness
- Medical history, including allergies
- Current medications and dosages
- Medical illnesses
- Surgical history
- Social history
- Family history
- Review of systems
- Physical exam
- Pertinent data
- Diagnostic impression
- Treatment plan and goals

ii. H&P prior to Inpatient Operative or Invasive Procedure and/or Anesthesia/Conscious Sedation shall include:

- All requirements listed in Section 3.13(d)(i) above
- Indications for the procedure
- Evaluation of the operative site
- Examination of the heart and lungs by auscultation
- Airway assessment
- ASA classification
- Sedation plan

iii. H&P for Ambulatory/Outpatients with Operative or Invasive Procedures and/or Anesthesia/Conscious Sedation shall include:

- Indications for the procedure
- Current medications and dosages
- Known allergies, including medication reactions
- Existing comorbid conditions
- Evaluation of the operative site

- Examination of the heart and lungs by auscultation
- Airway assessment
- ASA classification
- Sedation plan

iv. For Ambulatory/Outpatients with Operative or Invasive Procedures and Local Anesthesia or Peripheral Nerve Block patients, the H&P would qualify as a Pre-operative Note for Podiatrists to complete and shall include:

- Indications for the procedure
- Comorbid conditions
- Examination specific to the procedure being performed
- Allergies/medications

v. Behavioral Health Inpatient, Partial Program and Intensive Outpatient patient admitted to psychiatric hospital care, the H&P must be performed and documented no more than thirty (30) days before or forty-eight (48) hours after admission or registration and shall include:

- Reason for admission/chief complaint
- History of present illness
- Medical history, including allergies
- Current medications and dosages
- Medical illnesses
- Surgical history
- Social history
- Family history
- Review of systems
- Physical exam
- Pertinent data
- Diagnostic impression
- Treatment plan and goals
- Mental Status (Behavioral Health only)

(g) Emergency Services. If, due to an emergency, it is not possible to complete a pre-procedure H&P, the performing Practitioner shall, at a minimum, enter a notation describing the emergency and any available information relevant to the care of the patient, including but not limited to the patient's vital signs, available history and clinical and status. A complete H&P shall be performed and recorded as soon as possible.

(h) Pre-Admission H&Ps and Updates.[13] An H&P performed by a qualified Physician or Advanced Practice Clinician no more than thirty (30) days prior to the patient's admission or registration may be used (even if such pre-admission H&P is performed by a provider who is not a current Medical Staff or Advanced Practice Professional Staff Member); however, when a pre-admission/registration H&P is used, a qualified Staff Member must complete and document an updated examination of the patient, including any changes in the patient's condition that may be significant for the planned course of treatment. The qualified Staff Member shall use his/her clinical judgment, based upon his/her assessment of the patient's condition and co-morbidities (if any), in relation to the patient's planned course of treatment, to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient's medical record. If, upon examination, the Staff Member finds no change in the patient's condition since the pre-admission H&P was completed, he/she may indicate in the patient's medical record that the pre-admission H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the pre-admission H&P was completed. The updated H&P examination must be completed and documented in the patient's medical record: (a) prior to any non-emergent surgery, or any inpatient or outpatient procedure requiring anesthesia services, or (b) within twenty-four (24) hours after the patient's inpatient admission or outpatient registration, whichever occurs first. Any portion of the updated H&P performed by an Advanced Practice Professional shall be reviewed and co-signed by the admitting Physician or the Advanced Practice Professional's supervising Physician and such co-signing Physician accepts responsibility for the content of the pre-admission H&P and the updated H&P, unless the Advanced Practice Professional is licensed and privileged to independently perform on his or her own behalf

(i) Multiple Participants. More than one qualified Practitioner may participate in performing, documenting, and authenticating an H&P for a single patient. When performance, documentation, and authentication are shared among qualified practitioners, the practitioner who authenticates the H&P will be held responsible for its contents.[14]

(j) Readmission. If a patient is readmitted to the Medical Center within thirty (30) days for the same or a related problem, an interval H&P examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available.

(k) Consultation and Co-Signature Requirements. If any portion of the H&P is performed or documented by an Advanced Practice Clinician refer to AAH's Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

3.14 Psychiatric Evaluation.

[13] 42 CFR § 482.22(c)(5)(i); 42 CFR § 482.24(c)(2)(i)(B) (citing the Federal Register, 71 Fed. Reg. page 68676).
[14] 42 CFR § 482.24(c)(2)(i)(A) (citing the Federal Register, 71 Fed. Reg. page 68675).

(a) The Medical Staff Member who is responsible for the care and treatment of a patient admitted to psychiatric or substance abuse treatment at a dedicated mental health facility or unit will have a comprehensive mental health or addiction assessment performed and documented within twenty-four (24) hours for inpatient and direct admission residential care.[15]

(b) If a comprehensive mental health or addiction assessment has been performed and recorded by a Medical Staff Member within thirty (30) days of an inpatient, residential, a comprehensive assessment need not be performed upon admission; provided, however, that an update to such comprehensive mental health or addiction assessment has been performed and recorded in the patient's medical record noting the new chief complaint, reason for admission, current mental status and any other changes in the patient's condition within twenty-four (24) hours for inpatient and direct admission residential care.

3.15 Communications and Patient-Generated Information.

As needed to provide care, treatment and services, the medical record must contain entries describing communications with the patient and/or the patient's representatives (e.g., in-person discussion, telephone calls, emails, etc.) and any information generated by the patient. Such information may include: any advance directives and any informed consent, when required by AAH's Informed Consent/Informed Refusal Policy.

- Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.

3.16 Electrocardiographic (ECG) Strips and Reports.

Electrocardiograph strips and reports shall be filed as a permanent record in the patient's medical record. The attending Physician may retain a duplicate of the ECG strips and reports if so requested, but the original recordings shall remain in the patient's medical record.

3.17 Restraints and Seclusion.

The medical record must contain required documentation regarding the use of restraints or seclusion as specified in the AAH Restraint and Seclusion Policy.[16]

3.18 Adverse Events.

The medical record must contain a complete and accurate description of any adverse event (e.g., accidents, complications, hospital-acquired infections, unfavorable reactions to drugs or anesthesia, falls, etc.).[17]

[15] 42 C.F.R. § 424.24 (Local Coverage Determination (LCD): Psychiatric Partial Hospitalization Program (PHP) (L30491) February 2015).

[16] 42 CFR § 482.13(e).

3.19 Final Diagnosis, Discharge Order and Discharge Summary.
The medical record of Medical Center inpatients and certain outpatients must contain a final diagnosis (as applicable), a discharge order, and a discharge summary. Refer to the Medical Staff's Admission, Transfer and Discharge Policy for specific documentation requirements.

3.20 Ongoing Ambulatory Care Services.
For each patient who receives ongoing ambulatory care services, the medical record must contain a summary list that includes the following: (a) any significant medical diagnoses and conditions; (b) any significant operative and invasive procedures; (c) any adverse or allergic drug reactions; and (d) any current medications, over-the-counter medications, and herbal preparations. The summary list is updated whenever there is a change in diagnoses, medications, or allergies to medications, and whenever a procedure is performed.

4. INCOMPLETE RECORDS

4.1 Generally.
A medical record may be filed permanently incomplete when the attending physician who had treated the patient is no longer available to complete the record, and also when documentation is missing and cannot be located. The Medical Executive Committee may declare a medical record complete using the Permanently Incomplete Medical Record Approval form for purposes of filing when the attending Physician who treated the patient is no longer available to complete the records (e.g., death or incapacity of Practitioner, Practitioner no longer available to complete date entries), or when documentation is missing and cannot be located or accurately reproduced by the responsible Practitioner.

4.2 Documentation Requirement.
The purpose of having the Medical Executive Committee document the reasons for the permanent incompleteness is to document that good faith attempts were made to supply the missing information and that further attempts to obtain the missing information would not be fruitful or result in obtaining meaningful information to supplement the missing information. The purpose of the signature requirement is not for the signing party to assume responsibility for the care provided but to show the Medical Executive Committee made a proper determination that the Medical Center made a reasonable attempt to seek and obtain available information. By signing the statement, the individual is attesting to the futility of further efforts and validating the decision to permanently file away a medical record that is missing portions otherwise required to be in place.

5. MEDICAL RECORD AUDITS

The Medical Center (or its designee) conducts an ongoing review of medical records, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy,

[17] 42 CFR § 482.24(c)(2)(iv).

authentication, and completeness of data and information, and measures the delinquency rate at least quarterly.

6. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

All Staff Members agree to comply with Medical Center and AAH policies and procedures governing the use and disclosure of health information (commonly referred to as "Protected Health Information" or "PHI"), as may be amended from time to time. Inappropriate use and disclosure of PHI shall subject the Staff Member to the remedial action process specified in the Medical Staff Bylaws.

REFERENCES:

Wisconsin Administrative Code

- Wis. Admin. Code DHS § 124

Federal Regulations

- 42 CFR § 482.22
- 42 CFR § 482.24
- 42 CFR § 482.51
- 42 CFR § 482.52

FORM(S):

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MEDICAL EXECUTIVE COMMITTEE APPROVAL:

BOARD OF DIRECTORS APPROVAL:

Exhibit A

Time Frames for Completion of Medical Records

Type of Medical Record	Timeframe for Completion
General Medical Records	Within 30 days.
Emergency Department Records	Within 48 hours of the patient's discharge from the Emergency Department
New History & Physical	Must be performed, documented, and authenticated for each Medical Center inpatient no more than 30 days before or 24 hours after admission or registration, but prior to any non-emergent surgery, or any inpatient procedure requiring anesthesia services
Updated History & Physical	Within 24 hours of the patient's admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration
Preanesthesia Evaluation	Within 48 hours prior to surgery or a procedure requiring anesthesia services
Postanesthesia Evaluation	Within 48 hours after surgery or a procedure requiring anesthesia services
Brief Operative Note	Must be documented directly into the Medical Record before the Next Level of Care[18]
Procedure/Operative Note	Must be documented in the Medical Record within 24 hours following the procedure and must be signed within 4 days following the procedure.
Discharge Summary	Must be recorded and signed by the attending Physician within 3 calendar days of discharge

[18] **Next Level of Care** is defined as when a patient leaves Surgical/Procedural Area and goes to one of the following:

- **PACU** – the "next level of care" begins when the patient leaves PACU (Out of PACU)
- **Phase II** (*when a patient goes directly to day surgery/procedural area after a procedure to be discharged home and does NOT go to PACU first*) – the "next level of care" begins when the patient leaves Phase II (Phase II time complete).
- **ICU or Unit** – the "next level of care" begins when patient leaves the surgical/procedural area (Out of Room). If surgeon is in constant attendance with the patient during this transition this must be documented in the brief or full operative note immediately after transfer.

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