Mental Health Emergency Center		
Title: Hospital Medical Record Content Policy		**Document Number:**
Document Type: ☒ Policy ☐ Procedure ☐ Guideline ☐ Other		**Last Review/Revision Date:**
Content Applies to Patient Care: (Select all that apply) ☒ Adults ☒ Pediatrics (Under 18)	**Content Applies to:** (Select One) ☐ Clinical ☒ Administrative	**Next Review Date:** **Effective Date:**
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 the Medical Center'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 downtime or other event, every page included in a medical record must be clearly

[1] 42 CFR § 482.24 (Interpretive Guidelines). DNV MR 1 SR.1, SR.2 (September 2020)

labeled with patient label or two identifiers: the patient's complete name and medical record number. All handwritten entries must be made with a black pen (pencils and felt tip pens are not permitted) and must be legible . All paper documentation created must be incorporated 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]

2.3 Date, Time, Authentication and Co-Signature[3]

(a) Date, Time, Authentication. All medical record entries must be dated, timed , 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 2.4 and 2.7 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.[4] The co-signing Physician accepts responsibility for the content of the medical record entry.

2.4 Late Entries

Refer to the AAH Medical Record Documentation Policy.

2.5 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

[2] DNV MR.5 SR.3 (September 2020)
[3] 42 CFR § 482.24(c)(1); ,DNV MR.5 SR.1 (September 2020) EP 11 (Jul. 2015); DNV MR.5 SR.2, SR.3 (September 2020), EPs 2-4 (Jul. 2015); DNV MR.5 SR.4 (September 2020), EPs 1 & 3 (Jul. 2015). DNV M.5 SR.2, SR.4 (September 2020)
[4], DNV MR.5 SR.3 (September 2020) EP 1 and 2 (Jan. 2017).

care, treatment, and services; and (e) promote continuity of care among providers.[5] All medical records must be completed within the applicable time frames set forth in this policy [6]

2.6 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 Document Management System along with a list of approved abbreviations, symbols, and titles. If an unacceptable abbreviation is contained in the Staff Member order/note, the team member shall contact the Staff Member for clarification before carrying out the order.[7] The use of abbreviations when documenting the diagnosis is not allowed.

2.7 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 the 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. Team members 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. Team members should draw a line through entry (thin black pen line). Make sure that the inaccurate information is still legible.

iii. Team members must initial and date the entry.

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

v. Team members 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

[5] 42 CFR § 482.24(c)(1); DNV MR.5 SR.1 (September 2020), EPs 5-8 (Jan. 2017).
[6] 42 CFR §§ 482.24(b) and 482.24(c)(2)(viii); Wis. Admin. Code DHS § 124.14(3)(c)3 (2009); DNV MR.5 SR.4 (September 2020) , EP 2 (Jul. 2015).
[7] 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 AAH Amendment of Protected Health Information AAH 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.

2.8 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)
- Restraints and Seclusion (3.17)
- Adverse Events (3.18)
- Final Diagnosis and Discharge Summary (3.19)

3.1 General Requirements.

The medical record must contain information such as notes, documentation, records, reports, recordings, , 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[8]

The medical record must contain the patient's: (a) name, address, date of birth; (b) sex, (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

[8] DNV MR.5 SR.1 (September 2020) EP 1 (Jan. 2017).

The medical record must contain copies of any advance directives as specified in the AAH's "Advance Directives Policy Wisconsin".[9]

3.4 Allergies.
The medical record must identify the existence of any allergies to food, medications, latex, or other substances.[10]

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 their 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 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

[9] DNV MR.5 SR.2 (September 2020), EP 4 (Jul. 2015); DNV PR3 (September 2020) , EPs 9 & 11 (Jul. 2015).
[10] DNV MR.5 SR.2(September 2020) , EP 2 (Jul. 2015).

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.[11]

(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 their 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.[12]

[11] 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective July 10, 2015); Wis. Admin. Code DHS § 124.14(3)(a)12 (2009); DNV MR.5 SR.1, (September 2020) EP 7 & 8 (Jul. 2015); DNV MR.5 SR.1, (September 2020)EP 2 (Jul. 2015).

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, i [13] 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.[14]

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 Behavioral Health Informed Consent Wisconsin Policy.[15]

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.[16]

(b) Providers that may perform. Physicians, nurse practitioners, physician assistants, doctors of podiatric medicine, and 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, [17]

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[12] DNV MR.5, SR.4, SR.5 (September 2020).
[13] Wis. Admin. Code DHS § 124.18(1)(e)3 (2009).
[14] 42 CFR § 482.24(c)(4)(iii) (Interpretive Guidelines, effective July 10, 2015); Wis. Admin. Code DHS § 124.14(3)(a)8 (2009); , DNV MR.7, SR.3 (September 2020) EP 2 (Jul. 2015).
[15] 42 CFR § 482.24(c)(4)(v); DNV MR.7 SR.5 (September 2020), EPs 4 & 21 (Jul. 2015).
42CFR § 482.22)(c)(5)(i)
[17] 42 CFR § 482.22(c)(5)(i); 42 CFR § 482.24(c)(2); Wis. Admin. Code DHS § 124.14(3)(a)9 (2009); DNV MR.7 SR.1 (September 2020) , EP 3 (Jul. 2015).

(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 admission or registration, when the medical history and physical examination are completed within thirty (30) days b

(e) Emergency Department Notes. Practitioners may not use the emergency department notes to 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. Behavioral Health Inpatient, admitted to psychiatric hospital care, the H&P must be performed and documented no more than thirty (30) days before or twenty-four (24) 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) 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.[18]

(h) 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.

(i) Consultation and Co-Signature Requirements.[19] 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.

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.

[18] 42 CFR § 482.24(c)(2)(i)(A) (citing the Federal Register, 71 Fed. Reg. page 68675).
[19] DNV MS.17 SR.1, SR.4 (September 2020), EP 10 (Jul. 2015). The organized medical staff defines when a medical history and physical examination must be validated and countersigned by another Staff Member.

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, 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.

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.[20] Such information may include: any advance directives and any informed consent, when required by Behavioral Health Informed Consent Wisconsin Policy.

- Note: 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 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.[21]

3.17 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, falls, etc.).[22]

3.18 Final Diagnosis, Discharge Order and Discharge Summary.

The medical record of Medical Center inpatients and 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.

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

[20] DNV MR.5, SR.1 (September 2020), EP 4 (Jul. 2015).
[21] ;DNV PR.7 Restraint or Seclusion .(September 2020) ; DNV PR.7 Restraint or Seclusion (September 2020) 42 CFR § 482.13(e).
[22] 42 CFR § 482.24(c)(2)(iv).

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, 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

National Integrated Accreditation for Healthcare Organizations (NIAHO)-Revision 20-0

- Appendix B-Psychiatric Services

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: