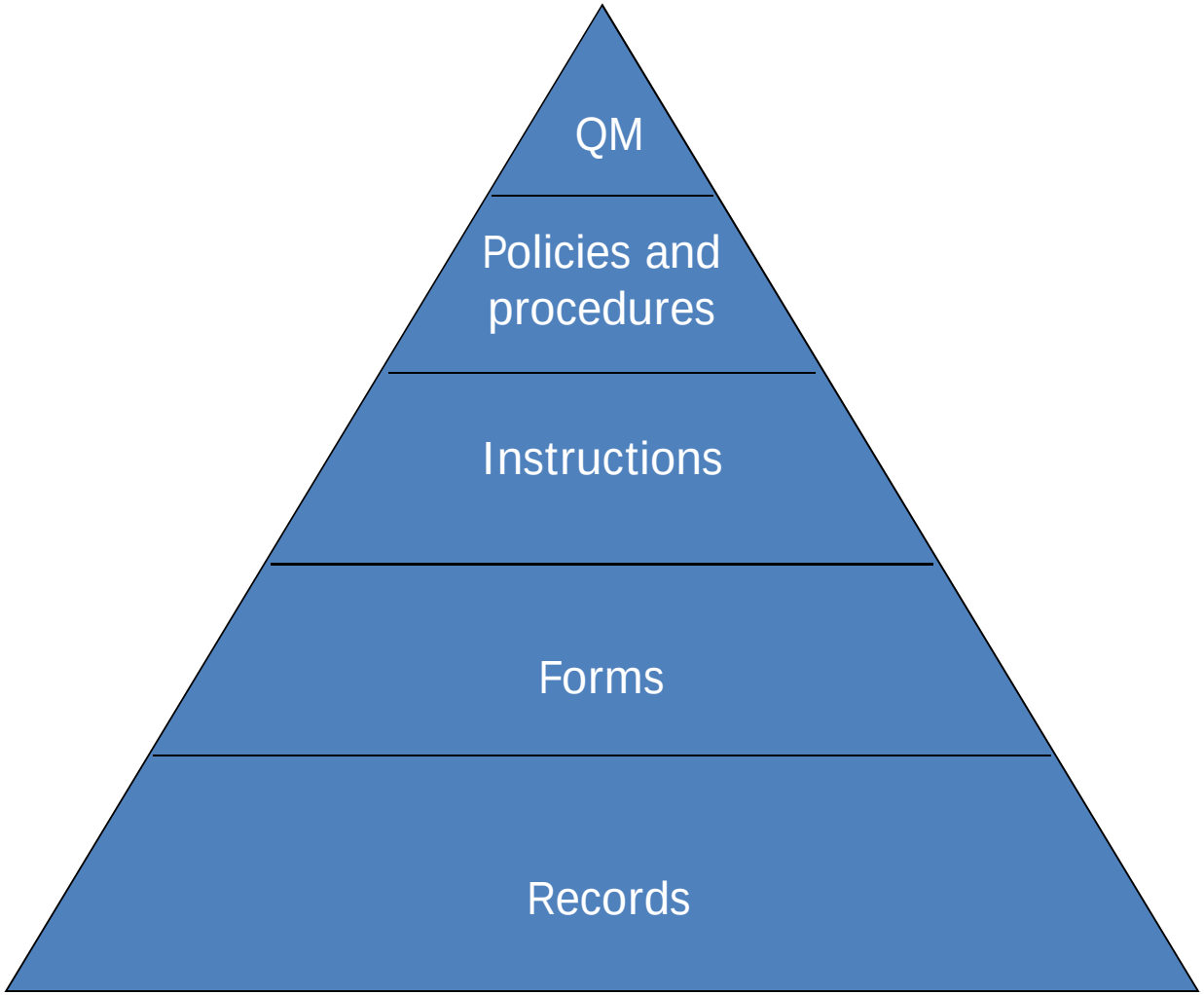
بسم الله الرحمن الرحيم

Hospital Documentation

Write what you think

Do what you write

Pyramid of documentation



Strategic planning

- Mission and vision
- SWOT
- Goals and objectives
- Strategies
- Evaluation of strategies

Quality Manual

- Quality improvement strategies ,goals and objectives
- Documentation guide and index

Policies

Answer to “*what ?*”

Example:

Management delegation of signature authority(permanent or temporary)

Procedures

Answer to “How?”

Example:

How to admit a patient or steps to admit?

Baghiatallah Hospital:

sample 1

sample 2

Data collection sheets

- Data code
- Data
- Rationale
- Responsible
- Frequency
- Frequency of analysis
- Audit of data collection
- Baghiatallah Hospital sample1
- Baghiatallah Hospital sample2

Job description

- Necessary qualifications
- Reporting relationship
- Responsibilities
- duties
- Training
- Quality activities

Committees

- Terms of references
- Committee report
- Tracking system

Quality Improvement Plan

- Goals
- Objectives
- Indicators
- Action planning
- Quality improvement log

Orientation program

- General and special
- Clinical and non-clinical

All must be with checklist

Other Documents

- Competency tests
- Appraisals(medical , nursing …etc)
- Internal audit report
- Adverse event report
- sentinel event reports

Patient’s records

Purposes of the Medical Record

Continuity of Care

Ø To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment;

Ø To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the care episode.

Communication Among Practitioners

Ø To document communication between the practitioner responsible for the patient and any other healthcare professional who contributes to the patient's care.

Legal Protection

Ø To assist in protecting the legal interest of the patient, the organization, and the practitioner responsible for the patient.

Data Resource

Ø To provide data for use in continuing education, in research, and in quality measurement, assessment, and improvement.

Identification Of The Patient

- Identification data
- Summary of psychosocial needs appropriate to patient age

Support For The Diagnosis

- Medical history
- Reports of relevant physical examinations
- Diagnostic orders

Justification For Treatment

- Evidence of appropriate informed consent
- Therapeutic orders
- Clinical observations

Documentation Of The Course And Results Of:

- Therapy
- Procedures and tests
- Conclusions at termination of treatment or evaluation

Patient-specific Data/Information Standards

- The organization defines, captures, analyses, transforms, transmits, and reports patient-specific data and information related to care processes and outcomes
- The organization initiates and maintains

a medical record for every individual assessed or treated.

Patient-specific Data/Information Standards(cont…)

- Only authorized individuals make entries in medical records.
- The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, *and promote continuity of care among healthcare providers.*

Confidentiality, Security, and Integrity

- Confidentiality, security, and integrity of data and information are maintained.
- Collection, storage, and retrieval systems are designed to allow timely and easy use of data and information without compromising its security and confidentiality.
- Records and information are protected against loss, destruction, tampering, and unauthorized access or use.

Uniformity, Standardization and Data Assessment

- Uniform data definitions and data capture methods are used whenever possible
- Minimum data sets, data definitions, codes, classifications, and terminology are standardized whenever possible.
- The hospital collects data in a timely, economic, and efficient manner and with the degree of accuracy, completeness, and discrimination necessary for their intended use.

Contents of The Medical Record

- Patient information and authorized representative;
- Legal status, for mental health services;
- Emergency care prior to arrival;
- Record and findings of the patient assessment;
- Conclusions/impressions from history and physical examination;
- Diagnosis or diagnostic impression;
- Reason(s) for admission or treatment

- Goals of treatment and treatment plan;
- Evidence of known advance directives;
- Evidence of informed consent if required;
- Diagnostic and therapeutic orders;
- All diagnostic and therapeutic procedures/tests performed and results;
- All operative and other invasive procedures performed;
- All progress notes;

- All reassessments;
- Clinical observations;
- Response to care provided;
- Consultation reports;
- Every medication ordered/prescribed for inpatients;
- Each medication dispensed/prescribed for ambulatory patient or inpatient on discharge;
- Every dose of medication administered and any adverse drug reaction;

- All relevant diagnoses;
- Any referrals/communications to external/internal care providers and community agencies;
- Conclusions at termination of hospitalization;
- Discharge instructions to the patient and family;
- Clinical resumes and discharge summaries, a final progress note, or transfer summary.

The Discharge Summary

- Reason for hospitalization;
- Significant findings;
- Procedures performed and treatment rendered;
- Condition on discharge;
- Specific instructions.

Pre- Operative and Operative Documentation

- Operative or other procedures and the use of anesthesia.
- Preoperative diagnosis
- Operative reports dictated or written immediately after surgery, including:
    1) *Primary surgeons and assistants;*
    2) *Findings;*
    3) *Technical procedures used;*
    4) *Specimens removed;*
    5) *Postoperative diagnosis*

Postoperative documentation

- Vital signs and level of consciousness;
- Medications and blood;
- Unusual events or postoperative complications;
- ID of nursing care providers;
- Discharge from PACU by by Relevant Discharge Criteria.

Emergency Care

When emergency, urgent, or immediate care is provided,….the medical record documents

- Time and means of arrival;
- Patients left against medical advise (AMA);

- Conclusions, including:
  - *Final disposition;*
  - *Condition at discharge;*
  - *Instructions for follow-up care.*
- Copy of record available to follow-up practitioner or medical organization.

Verbal Orders

- *Verbal orders* of authorized individuals are accepted and transcribed by qualified personnel who are identified by title or category in the medical staff rules and regulations
- Dated and identified by names of individuals *giving, receiving*, and implementing the orders;
  - Authenticated by the prescribing practitioner within the specified time period when required by law or regulation.

Entries & Authentication

- Every medical record entry is dated, its author identified, and, when necessary, authenticated.
- Entries made only by authorized individuals;
- Entries authenticated only by the author to verify they are complete, accurate, and final

Entries & Authentication

- Entries authenticated by written signature or initials, rubber stamp, or computer "signatures" or codes ,faxed signatures.
- Entries requiring authentication identified in policy, including at least H & P, operative reports, consultation, and discharge summaries.

Access to Information

- The [organization] can quickly assemble and have access to all relevant information from components of a patient's record, when the patient is admitted or is seen for ambulatory or emergency care.
- The medical record, computer system, or organization policy indicates when part of the record has been filed elsewhere

Medical Record Completion Requirements for Hospital

History and Physical:

- Within 24 hours after admission. May be done within 30 days prior to admission. For a readmission within 30 days for the same or related condition, an interval H & P is adequate if the original is available

Verbal orders:

- Signed within 24 hours

Informed Consent:

Evidence of compliance with requirements stated in the organization's policy and consistent with any legal requirements

Progress notes:

Chronological report of *clinical observations, condition changes, and results of treatment* (may be required daily) in hospital medical staff bylaws or rules and regulations

Operative Report:

"Immediately after surgery" (written if not dictated)

[Within 6 hours is usually acceptable with a postoperative note in progress notes];

Reports:

(lab, radiology, pathology, anesthesia, nuclear medicine, and diagnostic and treatment procedures) [Time limit for results, within 24 hours if possible, no longer in standards];

Clinical Resume:

Ø *Discharge Summary*: 30-day time limit in conjunction with the completion of the record [Most institutions require it within 2 weeks

Ø *Discharge instructions*: must include physical activity, medications, diet, and follow-up care;

A final Progress Note

- is acceptable instead of discharge summary if LOS is less than 48 hours for uncomplicated conditions, normal newborns, and uncomplicated deliveries;

Deaths:

- include reason for admission, findings, course, and events leading to death;

Autopsy Report:

- provisional anatomic diagnoses within 3 days;

complete report within 60 days.

19 Element Review

- Review must address timeliness and completeness of each element
- A portion of the 19 elements can be reviewed at each quarterly review provided all 19 elements are reviewed annually.
- If an element is reviewed annually the surveyors will want to see the last three years worth of data

Before the survey the organization completes the Summary Review Sheet, indicating at least quarterly findings for the review of each item as part of the ongoing medical record review process as well as performance improvement activities initiated to address findings if appropriate.

- Identification data
- Medical History:
  - chief complaint
  - present illness
  - past medical history
  - family history
  - social history
  - inventory by body system

- Age appropriate psycho-social assessment
- Report of relevant physical examinations
- H&P Conclusions or impressions
- Physician Plan of Care
- Diagnostic and therapeutic orders
- Informed Consent
- Clinical observations

- Progress notes
- Consult reports
- Operative/Invasive Procedure Reports
- Reports from diagnostic or therapeutic procedures
- Records of donation and receipt of transplants and/or implants

- Final diagnosis
- Conclusions at termination of hospitalization
- Discharge Instructions
- Discharge summaries
- Results of autopsies

با تشکر

والسلام علیکم