

Contents of the Patient Record

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Health care providers are responsible for maintaining a health record for each patient who receives health care services.

If the facility is accredited by an accreditation organization such as the Joint Commission or the American Osteopathic Association the provider must comply with standards that impact patient record keeping. In addition, the facility must meet federal and state laws and regulations that provide guidance for patient record requirements.

We need to take some time to review several general documentation requirements:

- The first one is authentication. This makes sense, once a health professional documents in the patient records the provider must sign or authenticate the entry by use of their signature and credential.
- All changes in the patient's condition must be documented.
- Any communication with the patient's family should be documented.
- All fields on pre-printed forms should be completed. If it is not applicable make sure that the patient understands to indicate N/A on the form.
- Make sure that health care providers are consistent in that they document all observations, outcomes, and progress of the patient.
- Make sure the documentation is continuous. Providers should never skip lines or leave blanks.
- Providers need to be objective; they need to state the facts about patient care and treatment and avoid documenting their opinions.
- Be sure that providers never reference other patient names in the patient record.
- All entries in the patient record are considered permanent. Health professionals are not allowed to delete or white out any entries made in the patient record.
- For the paper based record, make sure that forms are on white paper. Documentation should be made with permanent black ink, no photocopies, and avoid use of labels. Many years ago different shifts documented with different colors of ink such as red and green. These colors do not photocopy or scan well for electronic health records.
- Tell professionals to be as specific as possible and avoid vague entries.

The first form that is completed on admission is referred to as the face sheet. The face sheet is also known as the admission/discharge record. The face sheet is very important as it collects the required hospital data. The required hospital data includes demographic data, financial data, and clinical information.

The Uniform Hospital Discharge Data Set which is referred to as the (UHDDS) is the core data set for inpatient admissions. The data is collected on inpatient hospital discharges for the Medicare

and Medicaid programs. Much of the required information can be located on the face sheet. The official data set consists of the following information:

- Personal Identification/Unique Identifier
- Date of Birth
- Gender
- Race and Ethnicity
- Residence
- Health Care Facility Identification Number
- Admission Date and Type of Admission
- Discharge Date
- Attending Physician Identification
- Surgeon Identification
- Principal Diagnosis
- Other Diagnosis
- Principal Procedure and Dates
- Other Procedures and Dates
- Disposition of Patient at Discharge
- Expected Payer of Most of This Bill
- Total Charges

The National Committee on Vital and Health Statistics (NCVHS) recommends the following be collected as the standard data set on patients seen in an ambulatory and inpatient settings:

- Personal Identification/Unique Identifier
- Date of Birth
- Gender
- Race and Ethnicity
- Residence
- Living/Resident Arrangement
- Marital Status
- Self-Reported Health Status
- Functional Status
- Years Schooling
- Patient's Relationship to Subscriber/Person Eligible for the Entitlement
- Current of Most Recent Occupational/Industry
- Type of Encounter
- Admission Date (inpatient)
- Discharge Date (inpatient)
- Date of Encounter (ambulatory and physician services)
- Facility Identification

- Type of Facility/Place of Encounter
- Provider Identification (ambulatory)
- Attending Physician Identification (inpatient)
- Operating Physician Identification (inpatient)
- Provider Specialty
- Principal Diagnosis (inpatient)
- First Listed Diagnosis (ambulatory)
- Other Diagnosis (inpatient)
- Qualifier for Other Diagnosis (inpatient)
- Patient's Stated Reason for Visit of Chief Complaint (ambulatory)
- Physician's Tentative Diagnosis (ambulatory)
- Diagnosis Chiefly Responsible for Services Provided (ambulatory)
- Other Diagnosis (ambulatory)
- External causes of Injury
- Birth Weight of Newborn (inpatient)
- Principal Procedure (inpatient)
- Other Procedures (inpatient)
- Dates of Procedures (inpatient)
- Services (ambulatory)
- Medication Prescribed
- Medication Dispensed (Pharmacy)
- Disposition of Patient (inpatient)
- Disposition (ambulatory)
- Patient's Expected Sources of Payment
- Injury related to Employment
- Total Billed Charges

As you will note, most of the data that is collected can be found on the face sheet. Be sure to refer to the sample face sheet that is provided in our textbook. You will notice the top portion of the form collects the demographic data and bottom of the form collects the clinical data.

The following are key terms that you must become familiar with. If you are an MIC or an HIT student you will see these terms in your classification systems classes.

The **attending physician** establishes an admitting diagnosis upon the patient's admission to the hospital. This diagnosis is entered on the face sheet by the admitting staff. The admitting diagnosis can also be called provisional. This is the condition or disease in which the patient is seeking treatment.

The **principal diagnosis** can be defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Secondary diagnoses include comorbidities and complications which are known as (CC's).

A **comorbidity** can be described as a pre-existing condition that will, because of its presence with a specific principal diagnosis, cause an increase in the patient length of stay by at least one day in 75% of the cases. These would be chronic conditions such as asthma, hypertension, and diabetes.

A **complication** is an additional diagnosis that occurred after the beginning of the hospital admission that modifies the course of the patient's illness or the medical care required. A complication because of its presence can cause an increase in the patient length of stay by at least one day in 75% of the cases.

The **principal procedure** is performed for definitive or therapeutic reasons, rather than diagnostic purposes, or to treat a complication, or that procedure that is most closely related to the principal diagnosis.

Secondary procedures are additional procedures performed during an inpatient admission.

You will note that the diagnoses and procedures are located on the bottom portion of the face sheet. Upon discharge the physician is required to document this information. The physician cannot use abbreviations when documenting the diagnoses and procedures on the face sheet.

The Patient Self Determination Act (PSDA) requires all health care facilities to notify patients age 18 or over that they have the right to have an **advance directive**. Types of advance directives include the following:

- Do Not Resuscitate Orders (DNR)
- Living Wills
- Health Care Proxy or Durable Power of Attorney
- Organ or Tissue Donation

An **informed consent** is the process of advising patients about treatment options. In many situations the physician is responsible for informing the patient as well as documenting the following information in the patient's health records: patient diagnosis, the proposed treatment, reason for the treatment, possible complications, and the likelihood of success; alternative treatment options, and risk if the patient does not undergo treatment.

Other common consent forms that are utilized are the consent to admission and consent to release information.

The **consent to admission** is also referred to as the conditions of admission. The patient signs this form during the admission process. By signing this form the patient is consenting (agreeing) to receive medical treatment at the facility.

The **consent to release information** is also signed during the admission process. The patient is authorizing (providing consent) that the health care facility may release information for reimbursement purposes.

The next form that we we'll be discussing is the **emergency room record**, which is also referred to as the ER or ED. The Joint Commission has the following standards that address the criteria for the ER record. The standard includes the following: the time and means of arrival, conclusion at termination of treatment, disposition of the patient (this means where did the patient go after they were discharged – home, were they admitted here or to another facility, and so on), condition of the patient at discharge, and instructions for follow-up. The instructions for follow-up are very important, if the instructions are not provided to patient, the patient can sue the facility for abandonment.

The Emergency Medical Treatment and Labor Act (EMTLA) is required to be posted in emergency room. The purpose of EMTLA is to prevent facilities from “dumping patients” who are not able to pay. The law requires that the patient’s condition to be stable before transferring to another facility.

The **discharge summary**, which also referred to as a clinical resume, is the next form. If this helps, I always think of a resume as a summary about oneself, so a clinical resume is a summary of what happened to you while you were in the hospital. The Joint Commission requires the attending physician to complete the discharge summary within 30 days of discharge or the record is considered delinquent. A delinquent record can many times result in the suspension of a physician’s privileges. Suspension means that the physician may not admit patients or perform surgery. The Medical Staff Bylaws have set policies and procedures in place the specific record completion requirements and the suspension process.

The discharge summary documents the patient hospitalization, including the reason for admission, to include the chief complaint (CC), and the history of present illness (HPI), procedures performed, treatments, and services provided; patient’s condition on discharge, patient education to include instructions for self-care. The discharge summary must also include the facility identification, patient identification as well as admission and discharge dates. A discharge summary must also include the principal diagnosis, secondary diagnosis, if surgery was performed, the principal procedure, and secondary procedure. The attending physician is responsible for dictating, reviewing, and then signing the discharge for it to be complete.

A **discharge progress note** can be documented instead of a discharge summary if the patient has had an uncomplicated stay of less than 48 hours. This is referred to as a short stay record. The discharge progress note must contain documentation of the patient’s hospital outcome, condition on discharge, provisions for follow-up care including instructions, and final diagnosis.

This lecture is continued in Learning Unit 6.