

# Complying with the TJC Hospital Record of Care Chapter

Wednesday, November 19<sup>th</sup>, 2014



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# Learning Objectives

1. Discuss the importance of incorporating TJC standards into electronic charting.
2. Review the record of care elements that should be included in forms and documents.
3. Recall hospital requirements for auditing medical records.
4. Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
5. Evaluate compliance requirements and penalties.

# Record of Care Chapter

- New chapter in 2009 called “Record of Care, Treatment, and Services”
- Also referred to as the Documentation Chapter
- Abbreviated RC Chapter and includes 10 standards with 6 changes
- Most sections came from PC and IM chapters
- Two of the RC standards are top problematic standard for hospitals
  - RC.01.01.01 52% Reported in April 2014 Perspectives

# Record of Care Chapter 11 Sections

## Chapter Outline

### I. Plan

- A. Clinical Record Components (RC.01.01.01)
- B. Authentication (RC.01.02.01)
- C. Timeliness (RC.01.03.01)
- D. Audit (RC.01.04.01)
- E. Retention (RC.01.05.01)

### II. Implement

- A. Care, Treatment, and Services (RC.02.01.01, RC.02.01.03, RC.02.01.05, RC.02.01.07) (RC.02.01.09 through RC.02.01.27 are not applicable to hospitals)
- B. Not applicable to hospitals (RC.02.02.01)
- C. Verbal Orders (RC.02.03.07)
- D. Discharge Information (RC.02.04.01)

### III. Not applicable to hospitals (RC.03.01.01 and RC.03.01.03)



# Record of Care 10 Standards

	Standard Label	Standard Text	
▶	<b>RC.01.01.01</b>	The hospital maintains complete and accurate medical records for each individual patient.	^
▶	<b>RC.01.02.01</b>	Entries in the medical record are authenticated.	
▶	<b>RC.01.03.01</b>	Documentation in the medical record is entered in a timely manner.	
▶	<b>RC.01.04.01</b>	The hospital audits its medical records.	
▶	<b>RC.01.05.01</b>	The hospital retains its medical records.	
▶	<b>RC.02.01.01</b>	The medical record contains information that reflects the patient's care, treatment, and services.	
▶	<b>RC.02.01.03</b>	The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.	
▶	<b>RC.02.01.07</b>	The medical record contains a summary list for each patient who receives continuing ambulatory care services.	
▶	<b>RC.02.03.07</b>	Qualified staff receive and record verbal orders.	
▶	<b>RC.02.04.01</b>	The hospital documents the patient's discharge information.	v



# TJC Revised Requirements

- TJC has made many changes in their standards over the past two years since they must reapply for deemed status
  - Purpose is to bring their standards into closer compliance with the CMS hospital CoPs
  - TJC applies to CMS now for deemed status
  - Sign up for free publications at [www.jointcommission.org](http://www.jointcommission.org)

# TJC Revised Requirements

- Perspectives and Joint Commission Online is good place to look for changes such as
- July 2, 2014 added changes to RC.02.01.01 regarding documenting complications and hospital acquired infections
- Changes in 2013 to improve patient centered communication in RC.02.01.01
  - Must collect race and ethnicity information from patients
  - Collecting language data
- Deleted in 2012 RC.02.01.05 regarding documentation of restraint and seclusion
- Verbal order changes 2013
- Clarified documentation required for informed consent



# The CMS Conditions of Participation

- CMS also has a medical record section
- Published in the Federal Register<sup>1</sup>
- CMS then publishes Interpretive Guidelines and some have Survey Procedures
  - Final interpretive guidelines issued March 21, 2014 and updated more frequently
  - July 19, 2013 discharge planning memo
  - Medication and safe opioid use March 14, 2014 and July 11, 2014 many changes

<sup>1</sup>[www.gpoaccess.gov/fr/index.html](http://www.gpoaccess.gov/fr/index.html)

# CMS Hospital CoPs

- Changes to interpretive guidelines posted on the CMS website <sup>1</sup>
- Hospitals should check the below website once a month for changes
- Section on Medical Records starts at tag number A-0431
  - Some sections overlap with standards in the TJC RC Chapter
  - Have required things that need to be documented in the medical record

<sup>1</sup>[www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp](http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp)

# Location of CMS Hospital CoP Manuals

## Medicare State Operations Manual Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the "Download" column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

CMS Hospital CoP Manuals **new address**  
[www.cms.hhs.gov/manuals/downloads/som107\\_Appendixtoc.pdf](http://www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf)

App. No.	Description	PDF File
A	Hospitals	 <a href="#">2.185 KB</a>
AA	Psychiatric Hospitals	 <a href="#">606 KB</a>

# CMS Hospital CoP Manual

## State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents

*(Rev. 105, 03-21-14)*

### Transmittals for Appendix A

#### Survey Protocol

[www.cms.hhs.gov/manuals/downloads/som107\\_Appendixtoc.pdf](http://www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf)

#### Introduction

- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities



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## Policy & Memos to States and Regions



CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

### Select From The Following Options:

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Show only items containing the following word

There are **466** items in this list.

Sort by:

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<a href="#">Title</a> ▲ ▼	<a href="#">Memo #</a> ▲ ▼	<a href="#">Posting Date</a> ▲ ▼	<a href="#">Fiscal Year</a> ▲ ▼
<a href="#">INFORMATION: Reducing Avoidable Hospitalizations among Nursing Facility Residents; State Survey</a>	12-23-ALL	03/16/2012	2012
<a href="#">Healthcare Associated Infections (HAI) Prevention Program Environmental Scan of State Survey Agency</a>	12-22-NH	03/16/2012	2012
<a href="#">Instructions Concerning Waivers of Specific</a>			

[www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp](http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp)

# CMS Policy Memos

Home - General Information > Policy & Memos to States and Regions

[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html)

## Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
<a href="#">Fiscal Year (FY) 2014 Post Sequester Adjustment for Special Focus Facility (SFF) Nursing Homes</a>	14-20-NH	2014-04-18	2014
<a href="#">Publication of Notice of Proposed Rulemaking (NPRM) for Fire Safety Requirements – Informational Only</a>	14-21-LSC	2014-04-18	2014
<a href="#">Focused Minimum Data Set (MDS) and Dementia Care Surveys</a>	14-22-NH	2014-04-18	2014
<a href="#">Interim report on the CMS National Partnership to Improve Dementia Care in Nursing Homes: Q4 2011 – Q1 2014</a>	14-19-NH	2014-04-11	2014
<a href="#">Advance Copy: Update of State Operations Manual (SOM) Chapter 7 and Survey Process Timeframe Reminder</a>	14-18-NH	2014-03-28	2014
<a href="#">Outcome and Assessment Information Set (OASIS)-C1 Webinar: April 30, 2014</a>	14-17-HHA	2014-03-21	2014
<a href="#">Home Health Agency (HHA) State Operations Manual (SOM) revisions: Appendix B. HHA Enforcement Guidance and revisions to Chapter 2. Certification Process</a>	14-14-HHA	2014-03-14	2014
<a href="#">Requirements for Hospital Medication Administration, Particularly Intravenous (IV) Medications and Post-Operative Care of Patients Receiving IV Opioids</a>	14-15-Hospital	2014-03-14	2014

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**§482.24 Condition of Participation: Medical Record Services**

**The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.**

**Interpretive Guidelines §482.24**

The term “hospital” includes all locations of the hospital.

The hospital must have one unified medical record service that has administrative responsibility for all medical records, both inpatient and out patient records. The hospital must create and maintain a medical record for every individual, both inpatient and out patient evaluated or treated in the hospital.

The term “**medical records**” includes at least 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.

**Survey Procedures §482.24**

- Review the organizational structure and policy statements and interview the

*(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)*

*[All records must document the following, as appropriate:]*

**§482.24(c)(2)(vii) - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.**

**Interpretive Guidelines §482.24(c)(2)(vii)**

All patient medical records must contain a discharge summary. A discharge summary discusses the outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post hospital appointments, how post hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.

The MD/DO or other qualified practitioner with admitting privileges in accordance with State law and hospital policy, who admitted the patient is responsible for the patient during the patient's stay in the hospital. This responsibility would include developing and entering the discharge summary.

Other MD/DOs who work with the patient's MD/DO and who are covering for the patient's MD/DO and who are knowledgeable about the patient's condition, the patient's care during the hospitalization, and the patient's discharge plans may write the discharge summary at the responsible MD/DO's request.

In accordance with hospital policy, and [42 CFR Part 482.12\(c\)\(1\)\(i\)](#) the MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and MD/DO assistants to the extent recognized under State law or a State's regulatory mechanism.

Whether delegated or non-delegated, we would expect the person who writes the discharge summary to authenticate, date, and time their entry and additionally for delegated discharge summaries we would expect the MD/DO responsible for the patient



# CMS Discharge Summary Tag 468

## **A-0468**

**(Rev. 95, Issued: 12-12-13, Effective: 06-07-13, Implementation: 06-07-13)**

**[All records must document the following, as appropriate:]**

**§482.24(c)(4)(vii) - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.**

### **Interpretive Guidelines §482.24(c)(4)(vii)**

All patient medical records must contain a discharge summary. A discharge summary discusses the outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post hospital appointments, how post hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.

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delegated discharge summaries we would expect the MD/DO responsible for the patient during his/her hospital stay to co-authenticate and date the discharge summary to verify its content.

The discharge summary requirement would include outpatient records. For example:

- The outcome of the treatment, procedures, or surgery;
- The disposition of the case;
- Provisions for follow-up care for an outpatient surgery patient or an emergency department patient who was not admitted or transferred to another hospital.

**Survey Procedures §482.24(c)(4)(vii)**

- Verify that a discharge summary is included to assure that proper continuity of care is required.

# Transfer Form Must Include Following

*The “medical information” that is necessary for the transfer or referral includes, but is not limited to:*

- *Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;*
- *Brief description of hospital course of treatment;*
- *Patient’s condition at discharge, including cognitive and functional status and social supports needed;*
- *Medication list (reconciled to identify changes made during the patient’s hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);*
- *List of allergies (including food as well as drug allergies) and drug interactions;*
- *Pending laboratory work and test results, if applicable, including information on how the results will be furnished;*
- *For transfer to other facilities, a copy of the patient’s advance directive, if the patient has one; and*
- *For patients discharged home:*
  - *Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);*

# TJC Standards Topics

- MR needs patient's name, address, sex, DOB
- Reason for admission
- Initial diagnosis or condition
- Findings of assessment and reassessments
- Allergies to food and medications
- Conclusion drawn from H&P
- Consult reports
- Patient's responses to care and treatments

# TJC Standards Topics

- Emergency treatment given prior to arrival
- Progress notes
- Medications ordered or prescribed
- Plan of care and revisions
- Orders for tests and procedures
- Medication dispensed upon discharge
- Advance directives
- Informed consent

# TJC Standards Topics

- Records of communication including telephone calls or emails
- Patient generated information
- ED patients records include
  - Time and means of arrival
  - If patient left AMA
- Conclusions reached at termination of care such as final disposition, conditions, discharge instructions

# RC Chapter Topics

- Informed consent
- H&P
- Verbal orders
- Summary list by third outpatient visit
- Discharge information RC.02.04.01
- R&S documentation RC.02.01.05 removed
- Operative or high risk procedures and use of moderate sedation under RC.02.01.03
- Unanticipated outcome (UO) and disclosure

# Number One Problematic Standard

- **RC.01.01.01 (61% in 2012, 60% in 2013, 52% in April 2014 Perspective)** The hospital maintains complete and accurate medical
- 19 EPS but EP 2, 3, and 14-18 do not apply to hospitals
- Problematic ones:
  - EP 11 and 19 Regarding date and **TIME** of all entries
  - EP 6 The medical record needs to contain information to justify the patient's care and treatment (medical necessity)



# Complete Medical Record RC.01.01.01

- Standard: The hospital must maintain a complete and accurate medical record
  - 19 EPS
  - Only 11 apply to hospitals
- EP1 - The hospital has to define the components of a complete medical record
  - For example, H&P, consult reports, discharge summary, graphics, nurses notes, progress notes, verbal orders signed off, completed within 30 days, etc.

# Complete Medical Record

- EP4 to EP8 states that the medical record must contain:
  - Information that is unique to the patient that is used for identification
    - Name, address, DOB, medical record number etc.
  - Information needed to support the diagnosis and condition
    - Patient admitted for pneumonia with CXR verification, high WBC, decreased pulse ox, chest pain, etc.
  - Information to justify the patient's care and treatment (Important especially with RACs and the two midnight rule)

# Complete Medical Record

- EP4 to EP8 states that the medical record must contain (continued);
  - Information to document the course of care and the results
    - Information in progress notes and nursing notes show course of care
  - Information about the patient that promotes continuity of care
  - AHIMA practice brief has information to help determine what content must be in the MR

# AHIMA Maintaining a Legally Sound Record



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## Update: Maintaining a Legally Sound Health Record— Paper and Electronic

[www.ahima.org](http://www.ahima.org)

The health record is the legal business record for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. The standards may vary based on practice setting, state statutes, and applicable case law. An attorney should review policies related to legal documentation issues to ensure adherence to the most current standards and case law.

HIM professionals should fully understand the principles of maintaining a legally sound health record and the potential ramifications when the record's legal integrity is questioned. This practice brief will review the legal documentation guidelines for entries in and maintenance of the health record—both paper and electronic. Many of the guidelines that originally applied to paper-based health records translate to documentation in electronic health records (EHRs). In addition, new guidelines and functionalities have emerged specific to maintaining legally sound EHRs. It is of the utmost importance to maintain EHRs in a manner that will support a facility's business and legal processes, otherwise duplicate paper processes will need to be maintained.

AHIMA convened an e-HIM® work group to re-evaluate and update the 2002 practice brief

# Complete Medical Record

- EP9 - Standardized formats are used to document the care and treatment provided
- EP11 - All entries in the medical record are dated
  - Both TJC and CMS require that all orders be dated and TIMED as in EP 19
- EP12 - Hospital tracks the location of all components of the medical record
  - EKGs, ED triage notes, fetal heart strips, lab test results, etc.

# Complete Medical Record

- EP13 - Hospital must assemble or make available a summary in the medical record of all care provided to the patient
  - Summarize care provided in the ED or for a procedure in the discharge summary
  - MM.01.01.01 EP1 requires P&P that physician and staff have information available when participation in medication process (age, sex, diagnosis, allergies, current medications, etc.)

# Complete Medical Record

- EP19 - All entries must be TIMED
  - DS or deemed status which means it applies to most hospitals except VA so can get reimbursed for taking care of Medicare and Medicaid patients
  - This is one of the most common problematic standards by both TJC and CMS
  - This includes a date and **time** when verbal orders are signed off
  - Every entry including the order sheet and progress note must be dated and timed

# Authenticate Entries RC.01.02.01

- Standard: All entries in the medical record must be authenticated (signed off)
- 5 EPs
- EP1 - Only authorized individuals can make entries in the medical records
  - P&P should identify who can document
  - Examples: RNs, physicians, dieticians, nurses assistants, hospital attorney, pastoral care, etc.
  - AHIMA brief on how to do this for EHR or electronic health record



# AHIMA Attestation & Authorship 10-15-2013



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## Electronic Signature, Attestation, and Authorship (Updated)

*Editor's note: This update supersedes the November 2009 practice brief "Implementing **Electronic Signatures**."*

Electronic health record (EHR) systems provide the ability to sign entries electronically; however, implementing and using **electronic signatures** (e-signatures) is complex. This practice brief provides insight into the technology used to implement e-signatures, the related health IT standards, the regulatory environment, and recommendations on best practices.

This practice brief provides additional e-signature resources, tools, a glossary, and best practices to assist HIM professionals with EHR implementation and policy development.

While this practice brief addresses an organization's internal approach to determining e-signature policy and procedures, the foundational principles should extend beyond an organization's operations to external health information exchange efforts and participation agreements with HIE partners. As the healthcare industry evolves, an HIE's business plan and supporting functions must include valid, legal, consistent, and agreed-upon e-signature methods of nonrepudiation for use by all participants.

### An Evolving Definition of E-Signature

The EHR has changed certain concepts and terms related to signatures. In the past, HIM professionals identified the act of signing an entry as authentication. However, this definition has evolved.

In EHRs, **authentication** is the security process of verifying a user's identity that authorizes the individual to access the system (e.g., the sign-on process). Authentication is important because it assigns responsibility to the user for entries he or she creates, modifies, or views. **Attestation**, on the other hand, is the act of applying an e-signature to the content, showing authorship and legal responsibility for a particular unit of information.<sup>1</sup>

Signatures, like medical records, can be either **analog** (e.g., stored on paper and unable to be read by a computer) or **digital** (e.g., stored on electronic media such as disks that can be read by a computer). The term **electronic signature** is frequently used in references and regulations in reference to signatures in a digital format. However, an **electronic signature** is a generic, technology-neutral term for the various ways that an electronic record can be

# Electronic Signature Policy AHIMA

## **Electronic Signature, Attestation, and Authorship.**

### **Appendix C: Electronic Signature Model Policy**

*This template document is not intended for adoption as a substitute for a customized organizational policy of specificity and action steps appropriate to local factors.*

Advancing technology and changing surveillance criteria make any technology adaptation an evolution. An applied and reputable approach will balance front-end technology capabilities against back-end administrative controls to measure compliance.

Development of an electronic signature policy is an important aspect of a healthcare organization's legal electronic health record definition. AHIMA recommends legal counsel review the policy during the approval process. If technology limitations preclude implementation of optimal electronic signature approaches, organizations should identify gaps for future technology acquisitions and workflow improvements.

This model policy template recommends important legal and compliance considerations for healthcare organizations' electronic signature policy and procedures. An appropriate organizational policy reflects best practices along with germane international, federal, and state laws and regulations, accreditation standards, payer requirements, documentation requirements for clinical services offered, and technology functionalities.

Term definitions in this document are taken from the glossary in [appendix D](#). They are intended to be used together.

**Subject/Title Electronic Signature, Attestation, and Authorship for Medical Record Documentation**

# Countersignature

- EP2 - Define the types of entries in the medical record made by non-independent practitioners
  - Require countersigning
  - Required by law
- Countersignature requires a professional to review and if appropriate, approve action taken by another
- AHIMA has section on this in “Legal Documentation Standards”

## 2. **Countersignatures**

**Countersignatures** should be used as required by state law (i.e. graduate nurse who is not licensed therapy assistants, etc.). The person who is making the **countersignature** must be qualified to countersign. For example, licensed nurses who don't have the authority to supervise should not be countersigning an entry for a graduate nurse who is not yet licensed).

Practitioners who are asked to countersign should do so carefully. If there is a procedure involved, there should be some observation (i.e. view treatment or view dressing) to assure that it was done properly.

The federal regulations for long term care facilities do not require **countersignatures** for nurse practitioners and physician assistants. It is important to know state licensure and professional practice regulations for a NP/PA to determine if **countersignatures** are required.

# Countersignature

- Include in your P&P whether:
  - First year nursing student needs to be cosigned by clinical instructor
  - Two nurses sign to witness wasted narcotics
  - RN needs to co-sign LPN only if your policy requires this
  - Pharmacist cosigns for pharmacy tech if required
- Example: Student CRNA has done pre-anesthesia assessment countersigned by anesthesia provider

# Countersignature

- CMS Interpretive Guidelines for Hospitals (482.24(c)(1)(I)) require that medical staff (MS) R&R identify the types of documents or entries non-physicians may complete that require a countersignature by a supervisor or attending MS member
- If credentialed, state scope of practice allows, and hospital P&P allow, PA and NP can order respiratory and rehab treatments without a countersignature of physician

# Authenticate Entries

- EP3 - Need to be able to determine the author of each entry in the medical record
  - Sign each entry with name in accordance with P&P - full name or first initial and last name and some hospitals require a number after the name
- Nurse may use initials on the medication record with legend below
  - Hospitals may have physician also write down an identification number to make sure you can tell who wrote the order

# AHIMA Documentation Standards

state regulations and payer requirements.

## 1. **Signature**

Entries are typically authenticated by a **signature**. At a minimum the **signature** should include the first initial, last name and title/credential. A facility can choose a more stringent standard requiring the author's full name with title/credential to assist in proper identification of the writer. If there are two people with same first initial and last name both must use their full **signatures** (and/or middle initial if applicable).

Facility policies should define the acceptable format for **signatures** in the medical record.



# Authenticate Entries

- EP4 - Entries in the MR need to be authenticated by the author
  - Information introduced in the MR by transcription or dictation must be signed off by the author
  - Physician or LIP must sign off on a verbal order with date and time
  - A physician can affix an electronic signature, if electronic record, after dictating a H&P, operative report, or consult report
    - The electronic signature must be date stamped
    - Sign name and date and time if paper record

# Signature Stamp

- EP5 - The physician or person identified by the signature stamp or method of electronic signature is the only one who uses it
  - Physicians and others, should sign a form to this effect and create a list to cross reference to the individual
  - Include in P&P along with penalties for misuse
  - Many hospitals no longer allow signature stamps since Medicare and many other insurers and fiscal intermediaries will not pay if order is written and a signature stamp is used instead of signing the order

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## A Complete Ban on Signature Stamps

Oct 22, 2008 11:48 am | posted by Kevin Heubusch | Coding & reimbursement & Compliance & HIM operations

**UPDATE:** CMS has since released new [clarification](#) stating that stamps are not prohibited under the Conditions of Participation, but that some payers may not accept them.

The Centers for Medicare and Medicaid Services no longer accepts signature stamps on any record. CMS attempted to clarify the scope of the ban this summer, but the message may not have percolated to all corners of the industry yet.

In July [CMS stated](#) that "stamped signatures are not acceptable on any medical record." The prohibition applies to all providers and suppliers. Medicare will only accept "handwritten, electronic signatures or facsimiles of original written or electronic signatures."

In spring CMS published a ban on signature stamps focused narrowly on the certification of terminal illness for hospice. The subsequent July notice explicitly included all medical records.

In the upcoming November-December *Journal*, Gloryanne Bryant, RHIA, CCS, recommends that HIM professionals ensure compliance with the ban by participating in documentation checks in areas that have commonly used signature



# CMS Signature Guidelines

- April 16, 2010 CMS issues new signature guidelines and says no rubber stamps
- CMS issued a change request updating the Program Integrity Manual on signature guidelines for medical review purposes
- Requires legible identifier in form of handwritten or electronic signature
- Third exception is cases where national coverage determination (NCD), local coverage determination (LCD) or if CMS manual has specific guidelines takes precedence over above

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-08 Medicare Program Integrity</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 327</b>	<b>Date: March 16, 2010</b>
	<b>Change Request 6698</b>

**SUBJECT: Signature Guidelines for Medical Review Purposes**

**I. SUMMARY OF CHANGES:** Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare administrative contractors, the comprehensive error rate testing contractor, and recovery audit contractors ) are tasked with measuring, detecting and correcting improper payments in the fee for service Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language of the Program Integrity Manual required a legible identifier in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

**EFFECTIVE DATE: MARCH 1, 2010**  
**IMPLEMENTATION DATE: April 16, 2010**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)**  
**R=REVISED, N=NEW, D=DELETED**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	<b>3/3.4.1.1/Documentation Specifications for Areas Selected for Prepayment or</b>

contractors, or ACs), Medicare administrative contractors (MACs), the comprehensive error rate testing (CERT) contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language in the PIM required a “legible identifier” in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

**B. Policy:** Clarifies and updates various sections of the Program Integrity Manual.

**II. BUSINESS REQUIREMENTS TABLE**

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6698.1	All signature requirements in this CR are effective retroactively for CERT for the November 2010 report period.										CERT
6698.2	All signature requirements for ACs, MACs, PSCs and ZPICs are applicable for reviews conducted on or after 30 days after the issuance of this CR.	x	x	x	x	x					CERT, PSC, ZPIC
6698.3	For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.	x	x	x	x	x					CERT, PSC, ZPIC
6698.4	Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, (e.g. signatures on plans of care must be signed prior to services being rendered), those signature requirements take precedence.	x	x	x	x	x					CERT, PSC, ZPIC
6698.5	For medical review purposes, <u>if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the</u>	x	x	x	x	x					CERT, PSC,

		J B M A C	M E M A C	I	A R R I E R	H I	Maintainers					
							F I S S	M C S	V M S	C W F		
	<b>signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed in the PIM to discern the identity and credentials (e.g. MD, RN) of the signator.</b>											ZPIC
6698.6	<b>If there are reasons for denial unrelated to signature requirements the reviewer shall not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.7	<b>If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.8	<b>If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.9	<b>If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.10	<b>Reviewers may encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.11	<b>Reviewers shall consider all submitted signature logs regardless of the date they were created.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.12	<b>Reviewers shall NOT consider attestation statements where there is NO associated medical record entry.</b>	x	x	x	x	x						CERT, PSC, ZPIC
6698.13	<b>Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation</b>	x	x	x	x	x						CERT, PSC, ZPIC



[www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature\\_Requirements\\_Fact\\_Sheet\\_ICN905364.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf)

## Complying with Medicare Signature Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements and provides information on the documentation needed to support a claim submitted to Medicare for medical services and supplies.

**Please Note:**  
The information in this publication applies only to the Fee-For-Service Program (also known as Original Medicare).

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) improper payment rate, as required by the Improper Payments Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Improvement Act of 2012. CERT randomly selects a statistically-valid, stratified random sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates a national Medicare FFS paid claims improper payment rate and improper payment rates by claim type. The results of these reviews are reported annually.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare Trust Fund while protecting patients from medically unnecessary services or supplies. Table 1 provides answers to questions about Medicare signature requirements.





**Table 1. Medicare Signature Requirements Questions & Answers**

Question	Answer
<p>What is required for a valid signature?</p>	<p>For a signature to be valid, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>• Services that are provided or ordered must be authenticated by the ordering practitioner;</li> <li>• Signatures are handwritten, electronic, or stamped (stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of an inability to sign due to a disability); and</li> <li>• Signatures are legible.</li> </ul> <p>Reference: CMS "Medicare Program Integrity Manual" (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4 at <a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf">http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf</a> on the CMS website.</p>
<p>What should I do if I have not signed an order or medical record?</p>	<p>You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record. Your contractor may offer specific guidance regarding addenda to medical records.</p> <p>If an order for tests is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating "Ordering Lab" is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment.</p> <p>Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.3.2.4.</p>
<p>What if the physician signs the order or progress note, but the signature is not legible?</p>	<p>You may submit a signature log or attestation statement to support the identity of the illegible signature. If the original record contains a printed signature below the illegible signature, this may be accepted.</p> <p>Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.3.2.4.A.</p>
<p>What is a signature log?</p>	<p>A signature log is a typed listing of the provider(s) identifying their name with a corresponding handwritten signature. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation.</p> <p>Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.3.2.4.B.</p>

# CMS Signature Requirements

## 3.3.2.4 - Signature Requirements

(Rev. 465, Issued: 05-17-13, Effective: 06-18-13, Implementation: 06-18-13)

[www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)

This section is applicable for MACs, CERT, and ZPICs. This section does not apply to Recovery Auditors.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

**EXCEPTION 1:** Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

**EXCEPTION 2:** There are some circumstances for which an order does not need to be signed. For example, orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic

# Handwritten Signature CMS Program Integrity Manual

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, MACs and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

# Document Timely RC.01.03.01

- Standard: The hospital documents timely in the medical record
- EP1 - The hospital has a written P&P to require entries in the medical record be timely
  - Best to document ASAP while information is still fresh in your memory
  - Important when introducing MR into court room as Federal Rules of Evidence require that entries be made at or near the time the care was rendered
  - References PC01.02.03 EP1 where hospitals defines time frames to do assessments and reassessments

# Document Timely

- Important to communicate information to others
  - During hand offs
  - When nurse not available at the time physician or other healthcare provider is visiting patient
- Entries need to be timely for continuity of care and to prevent medical errors from occurring
  - Nurse told by mother she removed ticks from both boys, but didn't document until after first child died

# Document Timely

- EP2 - The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after discharge
  - Hospitals may want to consider having **discharge summary** dictated when patient discharged and then should document that it got it into the hands of the PCP before the first visit
  - May want to reengineer the discharge process
- EP3 - Hospital implements its P&P requiring staff to timely enter information in the MR
  - PC.01.02.03 EP1 requires hospital to specify time frame for doing initial patient assessment such as 2 hours (Can't be longer than 24 hours)

# Final CMS Discharge Planning Worksheet

Centers for Medicare & Medicaid Services  
HOSPITAL PATIENT SAFETY INITIATIVE (PSI)  
FY 2014 DRAFT RISK EVALUATION TOOL  
Discharge Planning

Name of State Agency:

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of interviews, observation, review of the hospital's discharge planning program documentation including policies and procedures, and review of medical records.

The interviews should be performed with the most appropriate hospital staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Please submit completed form by clicking the Submit Form button at the top of the page or by attaching the form to an email to [Hospital\\_DC@AcumenLLC.com](mailto:Hospital_DC@AcumenLLC.com).

**Section 1 Hospital Characteristics**

1. Hospital name:

2. CMS Certification Number (CCN):

--	--	--	--	--	--	--

3. Date of site visit:

		/			/					to			/			/			
--	--	---	--	--	---	--	--	--	--	----	--	--	---	--	--	---	--	--	--

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4	Patient/Record #5
4.18f Referrals, if applicable, to specialized ambulatory services, e.g. PT, OT, HHA, hospice, mental health, etc.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
4.18g Referrals, if applicable, to community-based resources other than health services, e.g. Depts. of Aging, elder services, transportation services, etc.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
4.18h Arranging essential durable medical equipment, e.g. oxygen, wheel chair, walker, hospital bed, commode, etc., if applicable.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
4.18i Sending necessary medical information to providers the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
NOTE: Only use N/A if the patient was transferred to a post-acute care facility or if the patient has a scheduled follow-up appointment with the attending physician.					



# CMS Discharge Planning Worksheet

- The CMS 2014 final discharge planning worksheet was changed in the final copy
  - Was discharge summary sent **before first post-discharge appointment** or within 7 days of discharge?
  - Was follow up appointment scheduled?
- Now says send necessary medical record information to providers the patient was referred prior to the first post-discharge appointment or 7 days, whichever comes first (820)

# Document Timely

- EP4 - The H&P, including updates, needs to be documented in the MR within 24 hours after inpatient admission and before surgery or a procedure requiring anesthesia (DS)
- CMS requires:
  - H&P be on chart within 24 hours of admission
  - H&P be no older than 30 days and updated prior to surgery
- Make sure H&P on chart before patient goes to surgery unless emergency and audit this

# MR Audits RC.01.04.01

- Standard: Hospital audits its medical records
- All hospitals have audit tools that are used to determine compliance with MR standards, guidelines and laws
- Some tools include concurrent monitoring to assure documentation is complete and timely at the present time as opposed to audits done after the patient is discharged

# Hospital Audit Tool

## OPERATIVE/INVASIVE QA Audit Tools

Surgery Date:

Surgeon:

MR#:

Procedure:

Indicators:	YES	NO	NA
1. Clinical Indication met			
2. Consent signed, dated and present in the medical record.			
2a. If No: Name of RN/Unit and forward copy to Director			
3. Time Out procedure and site marking by provider if applicable.			
If no: Name of RN/Unit and forward copy to Director			
4. Pre and Post Op diagnosis match			
5. Immediate post-op note by surgeon present			
5a. Note Dated and Timed by provider			
6. Documented H & P <30 days			
6a. H & P updated on day of surgery or completed on day of surgery			
7. Intra-operative complication of the procedure? (Physician review required)			
8. Amount of blood loss (Physician review if > 800 cc)			
9. Unplanned return to OR			
9a. Forward info to Risk			
10. Unplanned admission to ICU/CCU			

# AQI Audit/PI Tools Anesthesia

## Anesthesia Quality Improvement PACU Discharge

<b>Case Info</b>	
Date	
MR #	
ASA Class	

<b>Anesthesia type</b>	
Provider ID	
CRNA ID	
Additional provider	



	Yes	No
Patient is awake and able to contribute to assessment	<input type="checkbox"/>	<input type="checkbox"/>

[www.aqihq.org/qualitymeasurementtools.aspx](http://www.aqihq.org/qualitymeasurementtools.aspx)

Patient Physical Exam:	Yes	No
Mental Status at baseline (Y/N)	<input type="checkbox"/>	<input type="checkbox"/>
Vital Signs at baseline (Y/N)	<input type="checkbox"/>	<input type="checkbox"/>
Airway patency at baseline (Y/N)	<input type="checkbox"/>	<input type="checkbox"/>

Pain Score (10-point VAS scale):		
on PACU admission	<input type="checkbox"/>	<input type="checkbox"/>
Highest pain score	<input type="checkbox"/>	<input type="checkbox"/>
Pain score at time of assessment	<input type="checkbox"/>	<input type="checkbox"/>

Nausea or vomiting requiring treatment	<input type="checkbox"/>	<input type="checkbox"/>
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Any occurrence of vomiting	<input type="checkbox"/>	<input type="checkbox"/>
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Did the patient experience an unexpected event during perioperative care?	Yes	No
Unplanned ICU admission	<input type="checkbox"/>	<input type="checkbox"/>
Unplanned hospital admission	<input type="checkbox"/>	<input type="checkbox"/>
Intraoperative awareness	<input type="checkbox"/>	<input type="checkbox"/>
Epidural hematoma	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral neurologic deficit	<input type="checkbox"/>	<input type="checkbox"/>
Corneal abrasion	<input type="checkbox"/>	<input type="checkbox"/>
Agitation requiring treatment	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>
Other medication reaction	<input type="checkbox"/>	<input type="checkbox"/>
Delayed emergence	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory arrest	<input type="checkbox"/>	<input type="checkbox"/>
Reintubation	<input type="checkbox"/>	<input type="checkbox"/>
Dental trauma	<input type="checkbox"/>	<input type="checkbox"/>
Aspiration	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>

## Anesthesia Quality Improvement Intra-Operative

<b>Case Info</b>	<b>Anesthesia type</b>	
<b>Date</b>	<b>Provider ID</b>	
<b>MR #</b>	<b>CRNA ID</b>	
<b>ASA Class</b>	<b>Additional provider</b>	



### NO UNTOWARD EVENT

Death (Excludes ASA 6 patients presenting for harvesting)

Case Cancelled

Unplanned ICU Admission

Operation on incorrect site

Case Delayed

Unplanned admission of outpatient

Operation on incorrect patient

Incorrect procedure

Pulmonary Edema

Cardiac Arrest

Bronchospasm req treatment

Hypotension requiring unanticipated therapy with a continuous infusion or pressor agents

New PVC's, bradycardia, atrial fibrillation, or other dysrhythmias requiring unanticipated therapy

Myocardial ischemia, indicated by ST segment changes or echocardiography

Unanticipated difficult airway

Unplanned reintubation

Aspiration

Inability to secure an airway

Unplanned respiratory arrest

Laryngospasm

Anaphylaxis

Transfusion Reaction

Delayed emergence

Other unanticipated adverse reaction to medication

Use of sedation/narcotic reversal agents

Inability to reverse neuromuscular blockade

Malignant Hyperthermia

Medication error

High spinal

Failed regional anesthetic

Unintended dural puncture

Vascular access complication - vessel injury

Vascular access complication - pneumothorax

Local anesthesia systemic toxicity

# AHIMA List of P&P

Audit Schedule\*\*

Audit and Monitoring System\*\*

- Audit/Monitoring Schedule
- Admission/Readmission Audit
- Concurrent Audit
- Discharge Audit
- Specialized Audits (examples)
- Change in Condition
- MDS
- Nursing Assistant Flow Sheet
- Psychotropic Drug Documentation
- Pressure Sore
- Restrictive Device/Restraint
- Therapy

# Medical Record Audits

- EP1 - Hospital conducts an ongoing review of MRs at the point of care
- Audit must be based on the following indicators:
  - Presence
  - Timeliness
  - Legibility (if handwritten or printed)
  - Accuracy
  - Authentication
  - Completeness of data and information



## **MEDICAL RECORD AUDIT TOOL**

### **DIRECTIONS FOR COMPLETION**

This document is intended for use as a tool for a review of medical record documentation compliance with Joint Commission standards. Results from this audit may be used to identify systems or process deficiencies within the hospital, and can be used to prioritize improvement opportunities and facilitate staff education and training.

This tool should be used when completing a comprehensive open/closed record review. The questions are related to specific Joint Commission standards and Elements of Performance (EP), and each standard/EP can be referenced at the end of each question. Refer to the Joint Commission manual if further clarification regarding the intent of the standard is needed.

When completing this audit, there are two different response scales that are used:

<input type="checkbox"/> <b>N/A</b>	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
-------------------------------------	-------------------------------------	------------------------------------

- This scale applies to questions that indicate either the presence, or a lack thereof, of a specific documentation or process requirement within the medical record. Its use is self-explanatory.
- If the standard does not apply, check the "N/A" box.

Any pertinent comments regarding each standard may be recorded in the "Comments" section beneath each question. This field should be used to track key information to be used for staff education (including staff names to allow follow-up) or other performance improvement. Refer to the Medical Record Audit "Cheat Sheet" for guidance on where to locate specific elements for this audit within the medical record.

Name(s) of Auditor(s):

Date Audit Completed:

## PROVISION OF CARE Standards Review

1. If the patient was transferred (discharge status code 02 on face sheet), was it because the hospital does not perform the care, treatment, or service the patient required? (PC 1.1.10 #5)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comments: _____				
2. Is the completed H&P dated 30 days prior to or within 24 hours of admission? (PC 2.1.20 #5)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Admission time and date: _____ H&P time and date: _____				
Comments: _____				
3. If the patient is a surgical patient, was the H&P updated within 7 days of surgery? (PC 2.1.20 #7)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comments: _____				
4. Does the chart have a completed initial assessment? (Health Assessment I & II, N/A for OPS patients) (PC 2.1.30 #1)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comments: _____				
5. Has the patient's condition been updated since the initial assessment? (PC 2.1.20 #7)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comments: (numerator & denominator) _____				
6. When pain is identified, was the patient treated by the hospital or referred for treatment? (PC 2.1.50 #1)	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comments: _____				

# MR Audits

- MS.05.01.03 EP3 requires the MS to participate in auditing to determine that the MR are accurate, timely and legible
  - Common problematic standard is every entry needs to be timed
  - Also legibility is a problem
- Medication management tracer will ask staff about P&P if entry is illegible

# MR Delinquency Rate

- EP3 - Hospital measures its medical record delinquency rate at regular intervals, but no less than every three months
- What is your definition of legible such as if 2 individuals are unable to read
- Scribes can be used but need to have them sign and date and time with physician's immediate review and signature (Date and time and see TJC scribe FAQ)

## Human Resources (CAMH / Hospitals)

### Use of Unlicensed Persons Acting as Scribes

Revised | July 12, 2012

#### Q. What is a scribe and how are they used?

A. A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities.

Scribes also assist the practitioners listed above in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding.

Scribes are used most frequently, but not exclusively, in emergency departments where they accompany the physician or practitioner and record information into the medical record, with the goal of allowing the physician or practitioner to spend more time with the patient and have accurate documentation. Scribes are sometimes used in other areas of the hospital or ambulatory facility. They can be employed by the healthcare organization, the physician or practitioner or be a contracted service.

#### Q. Do the Joint Commission standards allow organizations to utilize scribes?

A. The Joint Commission does not endorse nor prohibit the use of scribes. However, if your organization chooses to allow the use of scribes the surveyors will expect to see:

Compliance with all of the Human Resources, Information Management, Leadership (contracted services standard) and Rights and Responsibilities of the Individual standards including but not limited to:

- A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities (HR.01.02.01, HR.01.02.05)
- Orientation and training specific to the organization and role (HR.01.04.01, HR.01.05.03)
- Competency assessment and performance evaluations (HR.01.06.01, HR.01.07.01)
- If the scribe is employed by the physician all non-employee HR standards also apply (HR.01.02.05 EP 7, HR.01.07.01 EP 5)

# MR Statistic Form

- EP4 - The medical record delinquency rate averaged from the last four quarterly measurements is 50% or less of the average monthly discharge (AMD) rate
- Each individual quarterly measurement is no greater than 50% of the AMD rate
- MR Statistics Form<sup>1</sup> can be used to calculate the quarterly and annual average medical record delinquency rate and form revised January 2014

<sup>1</sup> [http://www.jointcommission.org/Hospital\\_Medical\\_Record\\_Statistics\\_Form/](http://www.jointcommission.org/Hospital_Medical_Record_Statistics_Form/)

# MR Statistics Form Now in Survey Guide

HCO

**Accreditation**

**Survey Activity Guide**

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For Health Care Organizations

[www.jointcommission.org/assets/1/18/2014\\_Organization\\_SAG.pdf](http://www.jointcommission.org/assets/1/18/2014_Organization_SAG.pdf)

**2014**

# 2014 MR Hospital Statistics Form

## Hospital Medical Record Statistics Form (Determines compliance with RC.01.04.01 EP 4)

Organization ID: _____ City/State _____				Box #
<p><b>Average Monthly Discharge Rate (AMD):</b> Total number of inpatient discharges in the 12 months prior to survey ÷ 12. This number represents all inpatient records, and can include other records if they are observation visits, ambulatory surgery visits, endoscopy visits, cardiac catheterization visits, and Emergency Department visits. No other type of ambulatory or outpatient encounter may be included. Place this number in <b>Box #1</b>.</p>				1
<p><b>Medical Record Delinquency Timeframe:</b> Place the number of days within which a medical record must be completed, as specified within the Medical Staff rules and regulations, in <b>Box #2</b>. This value may not exceed 30 days. If the Medical Staff has not defined this value, or if the defined number exceeds 30, place the number 30 in <b>Box #2</b>.</p>				2
<p><b>Monthly Delinquency Totals</b></p> <p>Calculate the total number of medical records which are delinquent (not completed within the number of days specified in Box #2), on the last day of the month immediately preceding the survey. This is a cumulative number and includes all records still delinquent on the last day of that month, for any reason. This number represents all inpatient records, and <b>must</b> include other records such as observation visits, ambulatory surgery visits, endoscopy visits, cardiac catheterization visits, and Emergency Department visits, <b>if they were included in Box #1</b>. No other type of ambulatory or outpatient encounter may be included. Place this number in <b>Box #3</b>. Or, in other words: <b>Most recent month →</b></p>				3
• Use instructions for Box #3, for the mo. preceding the one in Box #3. This is the month of _____ Place # in <b>Box #4</b> . →				4
• Use instructions for Box #3, for the mo. preceding the one in Box #4. This is the month of _____ Place # in <b>Box #5</b> . →				5
• Use instructions for Box #3, for the mo. preceding the one in Box #5. This is the month of _____ Place # in <b>Box #6</b> . →				6
• Use instructions for Box #3, for the mo. preceding the one in Box #6. This is the month of _____ Place # in <b>Box #7</b> . →				7
• Use instructions for Box #3, for the mo. preceding the one in Box #7. This is the month of _____ Place # in <b>Box #8</b> . →				8
• Use instructions for Box #3, for the mo. preceding the one in Box #8. This is the month of _____ Place # in <b>Box #9</b> . →				9
• Use instructions for Box #3, for the mo. preceding the one in Box #9. This is the month of _____ Place # in <b>Box #10</b> . →				10
• Use instructions for Box #3, for the mo. preceding the one in Box #10. This is the month of _____ Place # in <b>Box #11</b> . →				11
• Use instructions for Box #3, for the mo. preceding the one in Box #11. This is the month of _____ Place # in <b>Box #12</b> . →				12
• Use instructions for Box #3, for the mo. preceding the one in Box #12. This is the month of _____ Place # in <b>Box #13</b> . →				13
• Use instructions for Box #3, for the mo. preceding the one in Box #13. This is the month of _____ Place # in <b>Box #14</b> . →				14
Quarterly Numerator Averages				Total Numerator Avg.
<b>Quarter 1</b>	<b>Quarter 2</b>	<b>Quarter 3</b>	<b>Quarter 4</b>	<b>Total</b>
Add the numbers in	Add the numbers in	Add the numbers in boxes	Add the numbers in boxes	Add the numbers in boxes



# MR Retention RC.01.05.01

- Standard: The hospital retains its MR as determined by P&P
- EP1 - The MR retention period is determined by its use and hospital P&P and is in accordance with law and regulation
- CMS hospital CoP retention period is 5 years for hospitals and 6 years for CAH
- There is a 10 year retention period required by CMS on blood and tissue records

# MR Retention RC.01.05.01

- AHIMA has a practice brief and chart on federal retention periods<sup>1</sup>
- Question 14 on the IRS Form 990 asks nonprofit hospitals if they have a policy on retention and destruction
- Establish a formal process for maintaining, retaining and destroying records

<sup>1</sup>[www.ahima.org](http://www.ahima.org)

# Retention & Destruction Medical Records 10/15/2013



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## Retention and Destruction of Health Information

*Editor's note: This update **supersedes** the August 2011 practice brief "Retention and Destruction of Health Information."*

Health information management professionals traditionally have performed retention and destruction functions using all media, including paper, images, optical disk, microfilm, DVD, and CD-ROM. The warehouses or resources from which to retrieve, store, and maintain data and information include, but are not limited to, application-specific databases, diagnostic biomedical devices, master patient indexes, and patient medical records and health information. To ensure the availability of timely, relevant data and information for patient care purposes; to meet federal, state, and local legal requirements; and to reduce the risk of legal discovery, organizations must establish appropriate retention and destruction schedules. This practice brief provides guidance on record retention standards and destruction of health information for all healthcare settings.

### Records Retention

The life cycle of records management begins when information is created and ends when the information is destroyed. The picture below provides a simple reflection of the entire records retention process. The goal for organizations is to manage each step in the record life cycle to ensure record availability. The creation of information is easy to establish, and most organizations do not have concerns when creating or using information. However, when maintaining information, various issues may arise.

## Appendix A: Federal Record Retention Requirements

Type of Documentation	Retention Period	Citation/Reference
Abortions and related medical services documentation	Maintain for three years.	42 CFR 50.309
Ambulatory surgical services	Retention periods are not specified	42 CFR 416.47
Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services	As determined by the respective state statute, or the statute of limitations in the state. In the absence of a state statute, five years after the date of discharge; or in the case of a minor, three years after the patient becomes of age under the state law or five years after the date of discharge, whichever is longer.	42 CFR 485.721(d)
Clinics, rural health	Six years from date of last entry and longer if required by state statute.	42 CFR 491.10 (c)
Competitive medical plans (See HMOs, competitive medical plans, healthcare prepayment plans)		
Comprehensive outpatient rehabilitation facilities (CORFs)	Five years after patient discharge.	42 CFR 485.60 (c)
Critical access hospitals (CAHs)	Six years from date of last entry, and longer if required by state statute, or if the records may be needed in any pending proceeding.	42 CFR 485.628 (c)
Department of Veterans Affairs		

**Table 1 -- AHIMA's Recommended Retention Standards**

Health Information	Recommended Retention Period
Diagnostic images (such as x-ray film)	5 years
Disease index	10 years
Fetal heart monitor records	10 years after the infant reaches the age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after the most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgical procedures	Permanently

### Recommendations

- Each healthcare provider should ensure that patient health information is available to meet

# Release of Original MR RC.01.05.01

- EP8 - Original MRs are not released unless the hospital is responding to law and regulation
  - Usually a copy of the medical record is released pursuant to a HIPAA authorization form
  - 563 pages HIPAA revisions effective date September 23, 2013
  - Usually the original MR should not be removed from the hospital
  - Occasionally, a court order may require the original records be brought to court
    - Ask if a certified copy of the original is acceptable

# MR Must Contain RC.02.01.01

- Standard: The medical record must contain information that reflects the patient's care and treatment
  - Amended July 2, 2014 EP 2
- EP1 - The medical record must contain the following demographic information
  - Patient's name, address, date of birth, and name of any legally authorized representative
  - Sex
  - Legal status of patient receiving behavioral health (incompetent with guardian or proxy, involuntary admission etc.)

# MR Must Contain RC.02.01.01

- The patient's communication needs, including preferred language for discussing health care
  - See also PC.02.01.21 EP1 The hospital effectively communicates with patient when providing care and treatment
  - Hospital identifies the patients' oral and written communication needs, including their preferred language such as glasses, hearing aids, Interpreter, white boards, TDD, caption TV,
- If patient is minor or incapacitated or has an advocate then document in the medical record



# Changes MR Must Contain

- Standard to improve patient centered communication
- Qualifications for language interpreters and translators will be met through proficiency, assessment, education, training, and experience
- Hospitals need to determine the patient's oral and written communication needs and their preferred language for discussing health care under PC standard
- Hospital will communicate with patients in a manner that meets their communication needs

# Changes MR Must Contain

- Collecting race and ethnicity data under RC.02.01.01 EP1 and moved to EP 28
- Collecting language data under RC.02.01.01 EP1
- The patient's communication needs, including preferred language for discussing health care
  - 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 is documented in the MR

# MR Must Contain

- EP2 MR must contain the following clinical information (Revised July 2, 2014)
  - Reason for admission or treatment
  - Initial diagnosis, diagnostic impression, or condition
  - All orders
    - CMS hospital CoP problematic standard
    - Make sure all orders for drugs and biologicals, rehab, radiology, and respiratory orders are recorded in the order sheet

# MR Must Contain

- Finding of assessments and reassessments
  - PC.01.02.01, EP1 - Hospital defines in writing the scope and content of screening, assessment, and reassessment information it collects
  - PC.03.01.03, EPs1 - Pre-sedation or pre-anesthesia assessment is done before surgery or a high risk procedure
  - CMS requires 48 hours before first drug is given to induce anesthesia
  - PC.03.01.03, EP 8 - Patient is reevaluated immediately before moderate or deep sedation

# MR Must Contain

- Allergies to food or medications
- Conclusions or impressions from the patient's medical H&P examination
- Diagnoses or conditions established during the patient's course of care **including complications and hospital acquired infections**
  - Often called healthcare associated infections or HAIs
- Consult reports

# MR Must Contain

- Observations and patient response to care
- Emergency care or treatment
- Progress notes
- Any medications ordered or administered along with dose, route and strength

# MR Must Contain

- Access site for medication, administration devices used, and rate of administration
- Adverse drug reactions (ADR)
- Treatment goals, plan of care, and revisions to the plan of care
  - PC.01.03.01, EP1 and 23 that requires the hospital to plan the patient's care based on their needs and assessment and has a result of diagnostic testing and revise as necessary
  - Plan of care common problematic standard

# MR Must Contain

- Results for diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge
- Discharge diagnosis
- Discharge plan and discharge planning evaluation



# MR Must Contain

- EP4 - MR must contain
  - **Advance directive (AD)** and RI.01.05.01, EP 11, requires that staff involved in patient's care are aware of whether or not the patient has an AD
  - **Informed consent** as required by hospital P&P and in accordance with RI.03.01 EP 11
    - Requires a discussion of about reasonable alternatives to the patient's proposed care or treatment
    - Requires a discussion of the risks, benefits, and side effects related to the alternatives, and the risks related to not receiving the proposed care or treatment

# MR Must Contain

- EP4 - MR must contain (continued)
  - Patient generated information
  - Records of communication with the patient including telephone calls or e-mail
    - Discharged patients with abnormal test results from the ED
    - Patients who had outpatient surgery

# MR Must Contain Psych Hospitals

- EP 10 For Psych hospitals that use TJC for DS
- Progress notes are recorded by the following individuals involved in the active treatment of the patient:
  - MD or DO responsible for the care of the inpatient, nurse, social worker or others involved in active treatment modalities
- The above individuals record progress notes at least weekly for the first two months of a patient's stay and at least monthly thereafter

# Emergency Department Care

- EP21 - The MR of a patient who receives urgent or immediate care or treatment contains
  - Time and means of arrival
  - If patient left AMA
  - Remember to include documentation to comply with EMTALA law
  - Copy of any information made available to the practitioner or medical organization providing follow-up care

# Emergency Department Care

- Conclusions reached at the termination of care
  - The patient's final disposition
  - Condition
  - Instructions given for follow-up care, treatment, and services
- EP 28 MR contains race and ethnicity
- EP 29 MR include patient self management goal and progress toward goals for hospitals that elect primary care medical home option

# TJC FAQ Format for Collecting Race/Ethnicity

## Rights and Responsibilities of the Individual (CAMH / Hospitals)

### Format for collecting patient race and ethnicity data

New | December 10, 2012

#### Q. Can the patient's race and ethnicity data be collected in the same question?

A. Race and ethnicity data may be collected in either a 1- or 2-question format. Although The Joint Commission does not specify which categories to use when collecting the patient's race and ethnicity information, the monograph *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*<sup>1</sup> provides guidance to help hospitals collect these data elements (pages 36-37). Hospitals are encouraged to use the race and ethnicity categories from the Office of Management and Budget (OMB) and US Census Bureau, and to consult resources such as the Institute of Medicine report *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*<sup>2</sup> and the *Health Research and Educational Trust Disparities Toolkit*<sup>3</sup>. These resources recommend the collection of Hispanic ethnicity and the following race categories: Black or African American, White, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Some other race. However, organizations also have the flexibility to collect granular ethnicity categories as applicable to the population served. For example, if your organization has a large Asian population, you may want to consider collecting additional ethnicity categories such as Chinese, Japanese, Filipino, etc.

While the preferred method of data collection is to ask the Hispanic ethnicity question first, followed by the recommended race categories, it is acceptable to combine Hispanic ethnicity and race into the same question.

1. The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010. Available at [http://www.jointcommission.org/Advancing\\_Effective\\_Communication/](http://www.jointcommission.org/Advancing_Effective_Communication/).
2. Ulmer C., McFadden B., Nerenz D.: *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press, 2009. Available at [http://books.nap.edu/openbook.php?record\\_id=12696](http://books.nap.edu/openbook.php?record_id=12696).
3. Hasnain-Wynia R., et al.: *Health Research and Educational Trust Disparities Toolkit*. Chicago, IL: Health Research & Educational Trust, 2007. Available at <http://www.hretdisparities.org>.

# Surgery or High Risk Procedure RC.02.01.03

- Standard: The medical record documents operative or high risk procedures and the use of moderate or deep sedation or anesthesia
- EP1 - Hospital documents surgery or high risk procedures and/or the administration of moderate or deep sedation
- EP2 - Provisional diagnosis needs to be documented by LIP before surgery or high risk procedure

# Surgery or High Risk Procedure

- EP3 - H&P is documented in MR before surgery or a high risk procedure
  - PC.01.02.03 EP5 requires H&P to be completed
    - Within 30 days prior to admission and update prior to surgery
    - Within 24 hours after inpatient admission
- Important for both CMS and TJC
- Audit compliance and make sure H&P on chart before patient goes to surgery unless it is an emergency



# Surgery or High Risk Procedure

- EP5 - Operative or high risk procedure report is written or dictated upon completion and before patient is transferred to the next level of care
  - If dictated then can write a progress note, or use stamp or sticker immediately after the procedure
  - If physician performing the procedure accompanies the patient from the OR to the next unit or area of care then report can be written or dictated in that unit such as in the PACU

# OP Report (CMS Also Requires)

- EP6 - Operative or high risk procedure report must include the following
  - Names of doctor or LIP who performed the procedure and assistants
  - Name of the procedure performed
  - Description and findings of procedure
  - Estimated blood loss (EBL) and if none write 0
  - Specimen removed
  - Postoperative diagnosis

# Surgery or High Risk Procedure

- EP7 - If the full operative or procedure report cannot be entered into MR immediately then need to include:
  - Name of primary surgeon
  - Name of assistants
  - Procedure done with description of finding
  - EBL, specimens removed and postoperative diagnosis
  - Many use a stamp or if EMR a special field

# Surgery or High Risk Procedure

- EP8 - MR must contain the following postoperative information
  - Vital signs (VS) and level of consciousness (LOC)
    - PC.03.01.05 EP1 - Requires that the patient's oxygenation, ventilation, and circulation are monitored continuously during surgery or during a high risk procedure
    - PC.03.01.07 EP1 - Requires that the patient's physiological status is evaluated immediately after surgery or as the patient is recovering from moderate or deep sedation

# Surgery or High Risk Procedure

- Postoperative information (continued)
  - Medications, including IV fluids and any administered blood or blood products
  - Unanticipated events or complications (including blood transfusion reactions) and management

# PACU Discharge Criteria

- EP9 - MR must document that the patient was discharged from post anesthesia care or from post-sedation by LIP responsible for their care or according to discharge criteria
  - Most hospitals have discharge criteria in the PACU such as the Modified Aldrete score or Modified Ramsey
  - If patient does not meet criteria then RN generally calls anesthesia provider for assessment and order to transfer out of PACU

# PACU Discharge Criteria

- EP10 - MR documents the use of approved discharge criteria to determine readiness for discharge
  - PC.03.01.07 EP 4 - LIP discharge from recovery area or according to criteria approved by clinical leaders
  - Follow ASPAN standards
  - Patient has good Aldrete scores and goes to floor or ambulatory unit
- EP11 - Postoperative documentation includes the name of the LIP responsible for discharge

# OR Register

- EP15 - OR Register must include the following (deemed status)
  - Patient name and identification number
  - Date and total time in surgery
  - Name of surgeon, assistants, and nursing personnel
  - Name of surgery
  - Frequent deficiency by CMS



# OR Register

- Type of anesthesia and person administering it
- Surgery performed
- Pre and post-operative diagnosis
- Age of patient
- Note CMS requires post anesthesia assessment within 48 hours, whether inpatient or outpatient except CAH must do before leaving the hospital
- If outpatient may need to call at home if not seen before patient left the hospital

# RC.02.01.05 Documentation R&S

- **REMOVED FROM RC CHAPTER**
- Standard - MR contains documentation of the use of restraint and seclusion (R&S)
- It is important to note that these apply to hospitals that do **NOT** use the TJC for deemed status so will **not** cover them in this presentation
- Therefore they only apply to hospitals such as the VA or Shiners
- TJC rewrote the R&S standards for hospitals to closely mirror the 50 pages of CMS restraint standards and TJC put the 10 standards in PC chapter

# Summary List Ambulatory RC.02.01.07

- Standard - MR must contain a summary list for each patient receiving ambulatory care services
- EP1 - The summary list is started by the third visit
- EP2 - Summary list includes; diagnosis, significant surgery or invasive procedures, ADRs, allergic drug reactions, and current medications including OTC and herbals

# Summary List Ambulatory

- EP3 - Update the summary list whenever there is a change in diagnosis, medications, allergies or new procedure is done
- EP4 - Summary list needs to be readily available to practitioners who need access to the information to provide care and treatment

# Verbal Orders Top Ten Problematic Standard

- **RC.02.03.07** Qualified staff receive and record verbal orders
  - There are 6 EPS but EP5 does not apply to hospitals
- Primary problem is that verbal orders are not signed off within the time frame set by the **state**
- If no state law then use to say how to sign off in 48 hours and now according to your policy
  - CMS allows any doctor on the case to sign off the verbal orders of any other physician on the case

# Verbal Orders RC.02.03.07

- Standard - Qualified staff receive and record verbal orders (VO)
- Top problematic standard for both TJC and CMS
- Person who takes the VO signs the order, dates and times it
- Make sure when doctor signs off the verbal it is both dated and TIMED
- EP1 - Hospital P&P needs to identify who is authorized to receive and record VO, as allowed by law

# Verbal Orders

- EP2 - Only authorized staff receive and record VO
  - Determine who can take and give VO
- EP3 - Documentation of VO includes:
  - Date and **time**
  - Name of person who gave order
  - Name of person who received and recorded the order
  - Name of person who implemented the order

# Verbal Orders

- EP4 - VO are authenticated within the time frame specified by law (deemed status)
  - Follow your state law. Some have 24 hours, 48 hours or 7 days
  - If state does not have a state law then CMS use to say you had to authenticate in 48 hours but this was changed so now follow your P&P
  - Authentication means writing name, date, and time of the order
  - Can authenticate by electronic signature



# Verbal Orders

- CMS allows PA and NP to sign VO if they could order it within their scope of practice
- EP6 - Documentation of VO includes time VO was received (DS)
  - Example: Lasix 20 mg PO daily  
VO Dr. Henry Smith/SDill RN 5-10-09 1315
- Remember to write down the VO and repeat it back

# Discharge Information RC.02.04.01

- Standard: The hospital documents the discharge information
  - Amended 9-29-2014 adding EP 1 and 2
- EP1 Documentation in the medical record of swing bed patients must include discharge information provided to the resident and to the receiving facility (DS)
- EP2 Swing bed resides must make sure discharge information includes reason for discharge or transfer, treatment provided, diet,

# Discharge Information RC.02.04.01

- EP2 Con't of information that must be documented in swing bed patients
- Medication order, referrals provided to the resident, name of LIP who is responsible for care, nutritional, physical and psychosocial status and potential for rehab
- Medical findings, diagnosis, summary of care and progress toward goals
- Any advance directives, discharge instructions provided to the patient, nursing information that would be useful in resident's care

# Discharge Information RC.02.04.01

- EP3 - In order to provide information to other care givers and facilitate continuity of care, the MR must contain a concise discharge summary
  - Not required for minor problems, as defined by MS, and a final progress note can substitute
  - Transfer summary may be substituted for discharge summary if patient transferred to different level of care within the hospital

# Discharge Summary

- The discharge summary must contain
  - Reason for hospitalization
  - Procedures performed
  - Care and treatment provided
  - Patient's condition and disposition at discharge
  - Information provided to patient and family
  - Provisions for follow up care
    - Example: did patient know diagnosis, what medications to take at home, diet to follow, activity level and what to do if symptoms should return

# Discharge Summary

- Note that CMS requires a discharge summary for all patients so it may just be in the terminology
- It must contain the outcome of hospitalization, disposition of the case and provisions for follow up
- Transfer summary may be substituted for a discharge summary if transferred to a different level of care within the hospital and caregivers change or use a progress note

# CMS Discharge Summary 468

- All medical records must have a discharge summary with outcome of hospitalization
- Disposition of the patient
- Provisions for follow up care
- Follow-up care includes post hospital appointments, how care needs will be met, and any plans for home health care, LTC, hospice or assisted living
- Can delegate to NP or PA if allowed by state law but physician must authenticate and date it and time it

# The End! Questions???



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# Standards

- American Society of Anesthesiologists (ASA) at [www.asahq.org/publicationsAndServices/sgstoc.htm](http://www.asahq.org/publicationsAndServices/sgstoc.htm)
- American College of Surgeons (ACS) at [www.facs.org/](http://www.facs.org/)
- American Association of periOperative Registered Nurses (AORN) at [www.aorn.org](http://www.aorn.org)
- American Society of PeriAnesthesia Nurses at [www.aspan.org](http://www.aspan.org)
- American Association of Certified Registered Nurse Anesthetists (CRNAs) at [www.aana.org](http://www.aana.org)

# American College of Surgeon

- Has positions statements that are reprinted from the Bulletin of the American College of Surgeons<sup>1</sup>
- Such as retained FBs after surgery, cell phone use in OR, blunt suture needles, statement on scope of practice, vendors in the OR, etc.
- Has guidelines such as standards in cardiac surgery and guidelines in office based surgery

<sup>1</sup>[http://www.facs.org/fellows\\_info/statements/statement.html](http://www.facs.org/fellows_info/statements/statement.html)

# AORN

- AORN position states such as correct site surgery, sponge counts, pediatric medication safety, fire prevention, on call, etc.
- Health care industry representative, creating a patient safety culture, role of scrub person, hypothermia, malignant hyperthermia, patient positioning, sterilization, etc.



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## AORN Position Statements

AORN position statements articulate the Association's official position or belief about certain perioperative nursing-related topics. Position statements are authored by a AORN Board of Directors appointees and are approved by the Board and the House of Delegates.

AORN has published position statements on the following topics:

- [Policy for Sunset of AORN Position Statements](#)
- [Allied Health Care Providers and Support Personnel in the Perioperative Practice Setting](#)
- [AORN Revised Statement on Patients and Health Care Workers with Bloodborne Diseases](#)
- [Statement on Correct Site Surgery](#)
- [Creating a Patient Safety Culture](#)
- [Statement regarding Criminalization of Human Errors in the Perioperative Setting](#)
- [Perioperative Care of Patients With Do-Not-](#)
- [Statement on One Perioperative Registered Nurse Circulator Dedicated to Every Patient Undergoing A Surgical or Other Invasive Procedure](#)
- [Orientation of the Registered Professional Nurse to the Perioperative Setting](#)
- [Orientation of the Surgical Technologist to the Perioperative Setting](#)
- [Statement on Patient Safety](#)
- [Pediatric Medication Safety](#)
- [Perioperative Advanced Practice Nurse](#)

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### Announcements

Two new position statements were approved by the House of Delegates at the 55th Annual Congress in Anaheim:

- [Surgical Smoke and Bio-Aerosols](#)

# ASPAN

- Has position statements such on overflow patients in PACU, use of UUAPs, safe medication administration, perianesthesia safety, postoperative N&V
- Has standards of perianesthesia nursing practice such as phase I level care, staffing guidelines, safe transfer of care, documentation requirements, etc.



# ASPAN

American Society of PeriAnesthesia Nurses

Serving nurses practicing in all phases of preanesthesia and postanesthesia care, ambulatory surgery, and pain management



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## Position Statements

The American Society of PeriAnesthesia Nurses has formulated the following position statements:

- [Cultural Diversity and Sensitivity in Perianesthesia Nursing Practice](#)
- [Medical-Surgical Overflow Patients in the Postanesthesia Care Unit \(PACU\) and Ambulatory Care Unit \(ACU\)](#)
- [Visitation in Phase I Level of Care](#)
- [Smallpox Vaccination Programs](#)
- [Entry into Nursing Practice](#)
- [Fast Tracking](#)
- [Minimum Staffing in Phase I PACU](#)
- [On Call/Work Schedule](#)
- [Perianesthesia Advanced Practice Nursing](#)
- [The Perianesthesia Patient with a Do-Not-Resuscitate Advance Directive](#)
- [Registered Nurse Utilization of Unlicensed Assistive Personnel](#)
- [A Joint Position Statement on ICU Overflow Patients developed by ASPAN, AACN and ASA's Anesthesia Care Team Committee and Committee on Critical Care Medicine and Trauma Medicine](#)
- [Nursing Shortage](#)
- [Safe Medication Administration](#)
- [Perianesthesia Safety](#)

# AHIMA Guidelines for Defining the Legal Record

## Data and Documents to Be Considered Part of the Record

- Advance directives
- Allergy records
- Alerts and reminders (see “Alerts, Reminders, and Pop-Ups,” above)
- Analog and digital patient photographs for identification purposes only
- Anesthesia records
- Care plans
- Consent forms for care, treatment, and research
- Consultation reports
- Diagnostic images
- Discharge instructions
- Discharge summaries
- E-mail messages containing patient-provider or provider-provider communications regarding care or treatment of specific patients<sup>5</sup>
- Emergency department records
- Fetal monitoring strips from which interpretations are derived
- Functional status assessments
- Graphic records
- History and physical examination records
- Immunization records
- Instant messages containing patient-provider or provider-provider communications regarding care or treatment of specific patients<sup>6</sup>
- Intake and output records
- Medication administration records
- Medication orders

## Documents Not Included in the Legal Health Record

### Administrative Data and Documents

Administrative data and documents should be provided the same level of confidentiality as the legal health record. However, administrative data should not be considered part of the legal health record and would not be produced in response to a subpoena for the medical record. Healthcare organizations might more appropriately consider some administrative data and documents as working documents.

Administrative data are patient-identifiable data used for administrative, regulatory, healthcare operation, and payment (financial) purposes. Examples of administrative data include:

- Abbreviation and do-not-use abbreviation lists
- Audit trails related to the EHR
- Authorization forms for release of information
- Birth and death certificate worksheets
- Correspondence concerning requests for records
- Databases containing patient information
- Event history and audit trails
- Financial and insurance forms
- Incident or patient safety reports
- Indices (disease, operation, death)
- Institutional review board lists
- Logs
- Notice of privacy practices acknowledgments (unless the organization chooses to classify



This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.

# Thank you for attending!



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