Policy Number: 100.12
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Originator: Medical Records Department	**Issue Date: 3/96**

Subject: Medical Record Standards/ 11/04 **Documentation Guidelines**	**Revision Date: 12/02, 2/04, 6/04,** 09/06; 05/07; 10/07; 2/09, 2/10, 2/11, 2/12, 2/13, 10/13

Scope: Clinical Providers, Nursing	**Approval/s: on file**

I.   POLICY

It is the policy of Facey Medical Group to provide medical record standards and documentation guidelines to ensure the medical record contains sufficient information to fulfill its purposes of providing continuity of patient care, providing data for legal proceedings, research, and substantiating insurance claims.

MEDICAL RECORD STANDARDS - every medical record must include the following:

- Problem List
- Allergies and adverse reactions – or a notation of no known allergies or history
- Medications – including dosages and dates of initial or refill prescriptions
- History and physicals
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening
- Advance Directive information
- Possible risk factors to the patient relevant to the particular treatment

GENERAL DOCUMENTATION GUIDELINES
1. A single medical record is established for each person receiving care.

2. Medical record entries are documented at the time service is provided.

3. Exchange of information among providers is timely, appropriate, and confidential.

4. All services provided directly by a PCP.

5. All ancillary services and diagnostic tests ordered by a practitioner.

6. All diagnostic and therapeutic services for which a patient was referred by a practitioner.

7. Documentation should be objective, clear and concise. No critical remarks of the care
     provided by other providers.

8. Follow the standard chart order format. Only include pre-approved forms in the medical record.

9. All entries must include identification of all providers participating in the patient's care and
     information on the services furnished by these providers such as date (month, day, & year), name
      of provider (first initial and last name) and title of author.

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10. Entries must be recorded in the EMR.

11. Use abbreviations and symbols only if their meaning is understood.

12. Identifying information on the patient such as patient name and medical record number must appear on every individual document

13. Retain the original of all reports.

14. Document and dictate all patient encounters, including physical exams, working diagnosis, treatment plans and inappropriate risk factors into the electronic medical record.

15. Document patient education performed and record patient understanding of instructions.

16. Indicate diagnostic work-up was reviewed by initialing and dating each report. Document a plan of care for significant abnormal test results.

17.   To correct an error draw a single line through the entry, write "error", initial and date the correction. White Out is never to be used.

18. Add patient corrections to the medical record as an addendum, without change or deletion to the original entry. The addendum should be identified as such and added to the medical record.

19. Medications ordered including dosages and dates of initial or refill prescription and or administered are to be documented and dictated into the electronic medical record as follows:

> **Nursing:**
> Immunizations - Allscripts Enterprise
> Inhalants - Progress Note
> Injections – Allscripts Enterprise
> IV Fluids - Progress Note
> Oral Medications – Allscripts Enterprise
> RX Refills – Allscripts Enterprise

20. Vital signs are to be entered into the electronic record.

21. Assessment Plan to be included in each note done by the provider of care.

22. "No Show" "Rescheduled", or "Canceled," will be documented in the EMR as appropriate to ensure appropriate medical care and monitor member non-compliance.