Documentation Requirements for the Acute Care Inpatient Record (2001)

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Editor's note: This practice brief is the first in an occasional series focusing on the content of documentation in various healthcare settings.

When developing organizational policies and procedures on documentation or evaluating current documentation systems, all applicable standards and regulations should be evaluated to ensure that a comprehensive system is in place. This practice brief will outline the documentation requirements for the acute care inpatient record as required by Joint Commission on Accreditation of Healthcare Organizations standards and the federal Conditions of Participation. In addition to accreditation standards and federal regulations, organizations must also reference state licensure regulations and payer policies (such as the Medicare Manual for Hospitals and Local Medical Review Policies), as well as professional practice standards.

The primary purpose of the patient record is for documenting the care of the patient. Whether the medical record format is paper-based or computer-based, HIM professionals strive to meet the challenges of documentation requirements. Beyond the main purpose of the documentation of patient care, the medical record is a tool for collecting, storing, and processing patient information. Records are being used daily for a multitude of purposes, including:

• providing a means of communication between the physician and the other members of the healthcare team caring for the patient

• providing a basis for evaluating the adequacy and appropriateness of care

• providing data to substantiate insurance claims

• protecting the legal interests of the patient, the facility, and the physician

• providing clinical data for research and education

General Guidelines for Patient Record Documentation

• Each hospital should have policies that ensure uniformity of both content and format of the patient record based on all applicable accreditation standards, federal and state regulations, payer requirements, and professional practice standards.

• The patient record should be organized systematically to facilitate data retrieval and compilation.

• Only persons authorized by the hospital's policies to document in the patient record should do so. This information should be recorded in the medical staff rules and regulations and/or the hospital's administrative policies.

• Hospital policy and/or medical staff rules and regulations should specify who may receive and transcribe a physician's verbal orders.

• Patient record entries should be documented at the time the treatment they describe is rendered.

• Authors of all entries should be clearly identifiable.

• Abbreviations and symbols in the patient record are permitted only when approved according to hospital and medical staff bylaws, rules, and regulations.

• All entries in the patient records should be permanent.

• Errors should be corrected as follows: draw a single line in ink through the incorrect entry, and print "error" at the top of the entry with a legal signature or initials, date, time, title, reason for change, and discipline of the person making the correction. Errors must never be obliterated. The existing entry should be left intact with corrections entered in chronological order. Late entries should be labeled as such.

• In the event the patient wishes to amend information in the record, it shall be done as an addendum, without change to the original entry, and shall be clearly identified as an additional document appended to the original patient record at the direction of the patient, who will thereafter bear responsibility for the explaining the change.

• The health information department should develop, implement, and evaluate policies and procedures related to quantitative and qualitative analysis of patient records.

• Review any requirements outlined in state law, regulation, or healthcare facility licensure standards as they relate to documentation requirements. If your state requires that verbal orders be authenticated within a specified time frame, accrediting and licensing agencies will survey for compliance with that requirement.

Joint Commission and Conditions of Participation Standards

Documentation Requirements	Joint Commission	Conditions of Participation
The hospital initiates and maintains a medical record for IM.7.1 every individual assessed or treated.	IM.7.1	
A medical record must be maintained for every individual 482.24 evaluated or treated in the hospital.		482.24
Only authorized individuals make entries in medical records. IM.7.1.1	IM.7.1.1	
Every medical record entry is dated, its author identified IM.7.8 and, when necessary, authenticated.	IM.7.8	
Hospitals establish policies and mechanisms to ensure Intent of IM.7.8 that only an author can authenticate his or her own entry. Indications of authentication can include written signatures or initials, rubber stamps, or computer "signatures" (or sequence of keys). The medical staff rules and	Intent of IM.7.8	

regulations or policies define what entries, if any, by house staff or non-physicians must be countersigned by supervising physicians.		
All entries must be legible and complete and must be 482.24 (c) (1) authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.		482.24 (c) (1)
The author of each entry must be identified and must 482.24 (c) (1) (i) authenticate his or her entry.		482.24 (c) (1) (i)
Authentication may include signatures, written initials, 482.24 (c) (1) (ii) or computer entry.		482.24 (c) (1) (ii)
The medical record contains sufficient information to IM.7.2 482.24 (c) identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers.	IM.7.2	482.24 (c)
To facilitate consistency and continuity in patient care, Intent of IM.7 the medical record contains very specific data and through IM.7.2information, including: • the patient's name, address, date of birth, and the name of any legally authorized representative • the legal status of patients receiving mental health services • emergency care provided to the patient prior to arrival, if any • the record and findings of the patient's assessment • conclusions or impressions drawn from the medical history and physical examination • the diagnosis or diagnostic impression • the reasons for admission or treatment • the goals of treatment and the treatment plan • evidence of known advance directives	Intent of IM.7 through IM.7.2	

• evidence of informed consent, when required by hospital policy

• diagnostic and therapeutic orders, if any

• all diagnostic and therapeutic procedures and test results

• all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate

• progress notes made by the medical staff and other authorized individuals

• all reassessments and any revisions of the treatment plan

• clinical observations

• the patient's response to care

• consultation reports

• every medication ordered or prescribed for an inpatient

• every medication dispensed to an ambulatory patient or an inpatient on discharge

• every dose of medication administered and any adverse drug reaction

• all relevant diagnoses established during the course of care

• any referrals and communications made to external or internal providers and to community agencies

• conclusions at termination of hospitalization

• discharge instructions to the patient and family

• clinical resumes and discharge summaries, or a final progress note or transfer summary. A concise clinical resume included in the medical record at discharge provides important information to other caregivers and facilitates continuity of care. For patients discharged to ambulatory (outpatient) care, the clinical resume summarizes previous levels of care.

The discharge summary contains the following information:

• the reason for hospitalization

• significant findings

• procedures performed and treatment rendered

• the patient's condition at discharge

• instructions to the patient and family

For normal newborns with uncomplicated deliveries, or for patients hospitalized for less than 48 hours with only minor problems, a progress note may substitute for the clinical resume. The medical staff defines what problems and interventions may be considered minor.

The progress note may be handwritten. It documents the patient's condition at discharge, discharge instructions, and follow-up care required.

When a patient is transferred within the same organization from one level of care to another, and the caregivers change, a transfer summary may be substituted for the clinical resume.

A transfer summary briefly describes the patient's condition at time of transfer and the reason for the transfer. When the caregivers remain the same, a progress note may suffice.

All records must document the following as appropriate: • admitting diagnosis• results of all consultative evaluations of the patient 482.24 (c) (2)(iii) • results of all consultative evaluations of the patient 482.24 (c) (2)(iii) and appropriate findings by clinical and other staff involved in the care of the patient • documentation of complications, hospital acquired 482.24 (c) (2)(iv) infections, and unfavorable reactions to drugs and anesthesia • properly executed informed consent forms for 482.24 (c) (2) (v) procedures and treatments specified by the medical staff, or by federal or state law if applicable, to require written patient consent • all practitioner's orders, nursing notes, reports 482.24 (c) (2)(vi) of treatment, medication records, radiology, and laboratory reports, vital signs, and other information necessary to monitor the patient's condition.		482.24 (c) (2) (ii) 482.24 (c) (2)(iii) 482.24 (c) (2)(iv) 482.24 (c) (2) (v) 482.24 (c) (2)(iii)
All medical records must document the following as appropriate: • discharge summary with outcome of hospitalization, 482.24 (c) (2)(vii) disposition of case, and provisions for follow-up care • final diagnosis with completion of medical records 482.24 (c) (2) (viii) within 30 days following discharge		482.24 (c) (2)(vii) 482.24 (c) (2) (viii)

A patient admitted for inpatient care has a medical history MS.6.2 and an appropriate physical examination performed by a qualified physician. (Qualified physician: A doctor of medicine or doctor of osteopathy who, by virtue of education, training, and demonstrated competence, is granted clinical privileges by the organization to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.)	MS.6.2	
Qualified oral and maxillofacial surgeons may perform MS.6.2.1 the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s).	MS.6.2.1	
Other licensed independent practitioners who are MS.6.2.2 permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges.	MS.6.2.2	
The findings, conclusions, and assessment of risk are MS.6.2.2.1 confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the medical staff) diagnostic or therapeutic interventions.	MS.6.2.2.1	
Dentists are responsible for the part of their patient's MS.6.2.2.2 history and physical examination that relates to dentistry.	MS.6.2.2.2	
Podiatrists are responsible for the part of their patient's MS.6.2.2.3 history and physical examination that relates to podiatry.	MS.6.2.2.3	
The medical staff determines those non-inpatient services MS.6.3 (for example, ambulatory surgery), if any, for which a patient must have a medical history taken and appropriate physical examination performed by a qualified physician who has such privileges. Except as provided in MS.6.2.1 through MS.6.2.2.3.	MS.6.3	

The patient's history and physical examination, nursing PE.1.7.1 assessment, and other screening assessments are completed within 24 hours of admission as an inpatient.	PE.1.7.1	
If a history and physical examination have been performed PE.1.7.1.1 within 30 days before admission, a durable, legible copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission.	PE.1.7.1.1	
Before surgery, the patient's physical examination and PE.1.8 medical history, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record.	PE.1.8	
There must be a complete history and physical workup 482.51 (b) (1) in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there must be a statement to the effect and an admission note in the chart by the practitioner who admitted the patient.		482.51 (b) (1)
A physical examination and medical history [are to] be done 482.24 (c) (2) (i) no more than seven days before or 48 hours after an admission for each patient by a doctor of medicine or osteopathy or, for 482.22 (c) (5) patients admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon who has been granted such privileges by the medical staff in accordance with state law.		482.24 (c) (2) (i) 482.22 (c) (5)
Plans of care are developed and documented in the patient's TX.5.3 medical record before the operative or other procedure is performed.	TX.5.3	
The hospital must ensure that the nursing staff develops 482.23 (b) (4) and keeps current a nursing care plan for each patient.		482.23 (b) (4)

All records must document all practitioners' orders. 482.24 (c) (2) (vi)		482.24 (c) (2) (vi)
All orders for drugs and biologicals must be in writing 482.23 (c) (2) and signed by the practitioner or practitioners responsible for the care of the patient.		482.23 (c) (2)
Verbal orders of authorized individuals are accepted and IM.7.7 transcribed by qualified personnel who are identified by title or category in the medical staff rules and regulations.	IM.7.7	
When telephone or oral orders must be used, they must be: • accepted only by personnel that are authorized to do so 482.23 (c) (2) (i) by the medical staff policies and procedures, consistent with federal and state law • signed or initialed by the prescribing practitioner 482.23 (c) (2) (ii) as soon as possible • used infrequently 482.23 (c) (2) (iii)		482.23 (c) (2) (i) 482.23 (c) (2) (ii) 482.23 (c) (2) (iii)
Signed x-ray reports of all examinations performed 482.26 (d) shall be made part of the patient's hospital record.		482.26 (d)
The radiologist or other practitioner who performs radiology 482.26 (d) (1) services must sign reports of his or her interpretations.		482.26 (d) (1)
The medical record thoroughly documents operative or IM.7.3 other procedures and the use of sedation or anesthesia.	IM.7.3	

A preoperative diagnosis is recorded before surgery by IM.7.3.1 the licensed independent practitioner responsible for the patient.	IM.7.3.1	
Operative reports dictated or written immediately after IM.7.3.2 surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis.	IM.7.3.2	
The completed operative report is authenticated by the IM.7.3.2.1 surgeon and filed in the medical record as soon as possible after surgery.	IM.7.3.2.1	
When the operative report is not placed in the medical IM.7.3.2.2 record immediately after surgery, a progress note is entered immediately.	IM.7.3.2.2	
Postoperative documentation records the patient's vital IM.7.3.3 signs and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications; and management of such events.	IM.7.3.3	
Postoperative documentation records the patient's IM.7.3.4 discharge from the postsedation or postanesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.	IM.7.3.4	
Compliance with discharge criteria is fully documented IM.7.3.4.1in the patient's medical record.	IM.7.3.4.1	
Postoperative documentation records the name of the IM.7.3.5 licensed independent practitioner responsible for discharge.	IM.7.3.5	
An informed consent for surgery shall be part of the 482.51 (b) (2) patient's chart before surgery is		482.51 (b) (2)

performed. It must be dated, timed, and signed by the patient and the physician informant.		
An operative report describing the reason for procedure, 482.51 (b) (6) gross findings, operative procedure (techniques), and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.		482.51 (b) (6)
A presedation or preanesthesia assessment is performed for TX.2.1 each patient before beginning moderate or deep sedation and before anesthesia induction.	TX.2.1	
A preanesthesia evaluation is performed within 48 482.52 (b) (1) hours prior to surgery by an individual qualified to administer anesthesia.	482.52 (b) (1)	
An intraoperative anesthesia record is provided. 482.52 (b) (2)		482.52 (b) (2)
With respect to inpatients, a postanesthesia follow-up 482.52 (b) (3) report is written within 48 hours after surgery by the individual who administers the anesthesia.		482.52 (b) (3)
A preanesthesia evaluation is documented by an individual 482.52 (b) qualified to administer anesthesia and is performed within 48 hours prior to the anesthesia event of surgery.		482.52 (b)
The hospital must maintain signed and dated reports of 482.53 (d) nuclear medicine interpretations, consultations, and procedures.		482.53 (d)
The practitioner approved by the medical staff to interpret 482.53 (d) (2) diagnostic procedures must sign and date the interpretation of these tests.		482.53 (d) (2)
When emergency, urgent, or immediate care is provided, IM.7.5 the time and means of arrival are	IM.7.5	

also documented in the medical record.		
The medical record notes when a patient receiving emergency, IM.7.5.1 urgent, or immediate care left against medical advice.	IM.7.5.1	
The medical record of a patient receiving emergency, urgent, IM.7.5.2 or immediate care notes the conclusions at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care.	IM.7.5.2	
When authorized by the patient or a legally authorized IM.7.5.3 representative, a copy of the emergency services provided is available to the practitioner or medical organization providing follow-up care.	IM.7.5.3	

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