GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.:	PAGE:
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Hospital-wide	December 12, 2016	A-RC200	1 of 10
TITLE: ENTRIES IN THE MEDICAL RECORD				
LAST REVIEWED/REVISED: 12/2016				
ENDORSED: HIMC 02/2016; EMC 04/2016				

PURPOSE:

To establish guidelines for the entries into the Medical Record, whether in paper or electronic format, that comprises the medical record.

POLICY:

Each medical record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

The medical record is a hybrid record, consisting of both electronic and paper documentation. The medical record physically exists in separate and multiple locations in both paper-based and electronic formats.

PROCEDURE:

I. Entries into the medical record are made only by authorized individuals:

A. Guam Memorial Hospital Authority (GMHA) privileged medical staff (Medical Doctor - MD, Doctor of Osteopathic Medicine - DO, Doctor of Podiatric Medicine – DPM, Doctor of Dental Surgery – DDS, Physician Assistant – PA, Certified Nurse Midwife – CNM, Certified Registered Nurse Anesthetist - CRNA, Allied Health Professionals – AHP. AHPs include diagnostic medical sonographers, dietitians, medical technologists, occupational therapists, physical therapists, radiographers, respiratory therapists, and speech language pathologists).

B. Other Guam medical physician(s) may write referral or consultation orders for outpatient treatment only (such as, rehab or radiological services).

C. Licensed nurses – RN, registered pharmacists – R.PH, Doctor of Pharmacy – PharmD.

II. Authors of entries are easily identified:

Authentication shows authorship and assigns responsibility for an act, event, condition, opinion, or diagnosis. A legally authenticated document or entry is defined as "a status in which a document or entry has been signed manually or electronically by the individual who is legally responsible for that document or entry."

A. A Signature Log Sheet for every patient account will be completed by all authors who document in the paper patient record. Every author must print their name clearly, indicate their credentials, and provide a sample signature and an alternate form of signature or initials used in the medical record. The Signature Log Sheet will be filed immediately after the Face Sheet.

B. A Signature Log, with sample signatures and initials of all authors authorized to document in the medical record are kept in the Medical Records Department.

III. Handwritten entries are made with permanent black or blue ink only (no erasable or water-soluble ink), to ensure the quality of electronic scanning, photocopying and faxing of the document. Never use a pencil to document in the medical record.
When documentation is printed from a computer for entry in the health record or retention as the permanent record, the print must be permanent.

IV. All entries in the medical record shall be legible, complete, dated, timed, authenticated and credentials indicated in written or electronic form by the individual responsible for providing or evaluating the service provided.

A. Entries must be legible to individuals other than the author. Physician orders, progress notes or other entries in the medical record that are not legible may be misread or misinterpreted and may lead to medical errors or other adverse patient events. If an entry cannot be read, the author should rewrite the entry on the next available line, define what the entry is for, referring back to the original documentation, and legibly rewrite the entry. For example: "Clarified entry of [date]" and rewrite entry, date, time and sign. The rewritten entry must be the same as the original.

B. **All entries must be complete.** A medical record is considered complete if it contains sufficient information to identify the patient, support the diagnosis/condition, justify the care, document the course and results of care, treatment and services and promote continuity of care among providers. Use specific language and avoid vague or generalized language. Do not speculate. The record should always reflect factual information (what is known versus what is thought or presumed), and it should be written using factual statements. If an author must speculate (i.e. diagnosis is undetermined), the documentation should clearly identify speculation versus factual information. Chart objective facts and avoid using personal opinions. Document the complete facts and pertinent information related to an event, course of treatment, patient condition, and response to care, and deviation from standard treatment (including reason for it).

C. All entries in the medical record must be dated, timed, authenticated and credentials noted in written or electronic form by the individual responsible for providing or evaluating the service provided.

1. The date and time of each entry must be accurately documented. A complete date includes the month, day and year. Time will be documented using the 24 hour clock otherwise known as military time. Time must be included in all types of narrative even if it may not seem important to the time of entry. Charting time as a block is not permitted. Timing establishes when an order was given, when an activity happened or when an activity is to take place. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or timeliness of various signs, symptoms or events. Entries should be made as soon as possible after an event or observation is made. An entry shall never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation shall indicate the actual time the entry was made with the narrative documentation identifying the time events occurred, if time is pertinent to the situation. The record must reflect the continuous chronology of the patient's healthcare.
2. Authentication of record entries may include written signatures, initials or computer key.

3. Authors of entries are identified through written signature samplings, rubber stamps with printed names and/or computer sign on.
4. Any entries made by residents or non-physicians, such as physician assistants or medical/nursing students that require countersignature, supervisory or attending physician are defined in the Guam Memorial Hospital Authority Medical Staff Rules and Regulations.
5. The practitioner must separately date and time his/her signature even though there may already be a date and time on the document.

    a. For certain electronically-generated documents where the date and time that the physician reviewed electronic transcription is automatically printed on the document, the requirements are satisfied.
    b. However, if the electronically generated document only prints the date and time that an event occurred (e.g. EKG printouts, lab results, etc.) and does not print the date and time that the practitioner actually reviewed the document, then the practitioner must either authenticate, date and time the document itself or incorporate an acknowledgement that the document was reviewed into another document (such as an H&PE, Progress Note, etc.) Which would then be authenticated, credentials indicated, dated and timed by the practitioner.

V. Verbal /telephone orders can only be given by a member of the Medical Staff of GMHA and taken by a GMHA staff licensed nurse, Allied Health Professional or PharmD. The names of the individuals who gave, received, recorded, and implemented the order(s) must also be indicated.

A. Only a licensed Pharmacist or licensed nurse may receive and record verbal/telephone orders of medications. Respiratory Technicians, Physical Therapists, Imaging/Radiology Technicians and/or Technologists and Nuclear Medicine Technicians may also receive/record telephone/verbal orders but only within the scope of their specialty allowed by law.
B. The order shall be written on the Physician Order Sheet by the person receiving the order.
C. The date and time the order is received must be indicated.
D. The order must include "VORB" (verbal order read back) or "TORB" (telephone order read back).
E. The name of the member of the Medical Staff issuing the order and the receiver's signature and credentials.
F. Ordering practitioner shall co-sign, indicate their credentials, date and time the order within 48 hours.

VI. When an error is made on an entry whether manual or electronic, the corrected entry shall be added as soon as the error is discovered. When correcting or making a change to an entry in a computerized health record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where a hard copy is printed from the electronic health record (EHR), the hard copy must also be corrected.

The author shall indicate the error by making a single line through the entire text, making sure that the inaccurate information is still legible. Write "error" by the incorrect entry and state the reason for the error in the margin or above the note if there is room followed by his/her initials and credentials, the date and time of the initials. An attempt to erase or otherwise obliterate or alter the original entry by blacking out with marker, using whiteout, or writing over an entry should never be made.

VII. All documentation and entries in the medical record, both paper and electronic, must be identified with the patient's full name, medical record number and patient account number. Each page of double-sided or multi-page forms must have the patient label. Labels are not to be placed over documentation so to ensure legibility.

VIII. Progress Notes shall be written daily for all patients, however for patients admitted to the Skilled Nursing Unit level, physicians are only required to document at least weekly or more frequently, if necessary.

IX. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

A. Document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.
B. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.
C. Identify the new entry as a "late entry". Enter the current date and time. Do not try to give the appearance that the entry was made on a previous date or time.
D. Identify or refer to the date and circumstance for which the late entry or addendum is written. If the late entry is used to document an omission, validate the source of additional information as much as possible (e.g., where you obtained the information to write the late entry).

X. An amendment is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or circumstance. When making an amendment:

A. Document the current date and time.
B. Write "addendum" and state the reason for the addendum referring back to the original entry.
C. Identify any sources of information used to support the addendum.
D. When writing an addendum, complete it as soon after the original note as possible.
E. In an electronic system, include a link to the original entry or a symbol by the original entry to indicate the amendment.

If a patient or his or her representative requests for an amendment to his/her record a separate entry (progress note, form, or typed letter) can be used for patient amendment documentation. The amendment should refer back to the information questioned, date, and time. The amendment should document the information believed to be inaccurate and the information the patient or legal representative believes to be correct. The entry in question should be flagged to indicate a related amendment or correction (in both a paper and electronic system). At no time should the documentation in question be removed from the chart or obliterated in any way. The patient cannot require that the records be removed or deleted.

XI. AHP's may write orders only in the area of their expertise, consistent with the scope of services individually defined. Narcotic orders must be countersigned by the responsible supervising physician within 48 hours from the time the order was given.

XII. History & Physical Examination (H&PE)
A History and Physical Examination shall be completed no more than 30 days prior to or twenty-four (24) hours after a patient's admission to the hospital. It shall include:

A. Date of Examination
B. Medical History
    1. Chief complaint
    2. History of current illness, including when appropriate; assessment of emotional, behavioral and social status.
    3. Relevant past history, family and/or social history appropriate to the patient's age.
    4. Review of body systems.
    5. A list of current medications and dosages.
    6. Any known allergies, including past medication reactions and biological allergies.
    7. Existing co-morbid conditions.

C. Physical Examination: Current physical assessment
D. Professional Diagnosis: Statement of conclusions or impressions drawn from the medical history and physical examination
E. Initial Plan: Statement of the course of action planned for the patient while in the hospital.

A legible copy of an H&PE performed within 30 days prior to the hospital admission is acceptable provided the report is recorded by a member of the GMHA medical staff. All outside records must be in a form approved by the hospital and must be compatible with current medical records policies and procedures. An original signature is placed on the document by the attending physician. In such instances when the H&PE is written prior to the admission, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must be recorded within 24 hours of the patient's admission.

For normal vaginal deliveries a current complete and legible prenatal record from the attending practitioner's office may be used in lieu of an H&PE but in addition to the record, an admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

An H&PE must be present in the chart before any inpatient or outpatient elective invasive procedure is performed. If the H&PE was done more than 24 hours prior to a procedure, an update note is required. The update note is to include any components of the patient's current medical status that may have changed since the H&PE or to address any areas where more data is needed, and confirming the necessity for the procedure is still present.

For dental and podiatric patients, the attending physician is responsible for the H&PE. The Dentist and Podiatrist are responsible for the part of their patients that relates to dentistry or podiatry.

In cases of emergencies when the surgeon is unable to write or dictate a complete H&PE, a brief note is required by the surgeon. The note should include, critical information about the patient's condition including pulmonary status, cardiovascular status, Blood Pressure, Vital Signs, etc.

The previous H&PE is acceptable for patients readmitted within 30 days of discharge for the same diagnosis, provided an interval admission note is included.

The attending physician is responsible for the H&PE, unless it was already performed by the admitting physician.

XIII. Consultation Report is due within twenty-four (24) hours of the request.

The requestor must complete consultation form indicating:
A. Consulting physician's name
B. Date and time of request
C. Reason for consultation

The consultant shall record:
A. Evidence of review of the patient's record.
B. Pertinent findings on examination of the patient.
C. The Consultants opinion and recommendation.

Consultants must be members of GMHA medical staff and must have full privileges in the field in which their opinion is sought.

XIV. Consents for treatment and/or surgical operations shall be obtained from the patient or his/her representative except where such consent may result in delaying the administration of treatment or the performance of the necessary surgical operation (i.e. emergency cases).

XV. A licensed independent practitioner involved in the patient's care shall document the provisional diagnosis in the progress notes of the medical record, before an operation or other high risk procedure is performed.

XVI. The Post-Operation progress note shall be entered into the medical record before the patient is transferred to the next level of care in order to provide pertinent information for any individual required to attend to the patient.

XVII. An Operation or other high-risk procedure report is written or dictated upon completion of the operation or other high-risk procedure and before the patient is transferred to the next level of care.

Note 1: The exception to this requirement occurs when an operation or other high risk procedure progress report note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.

Note 2: If the practitioner performing the operation or high risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

It shall include:
A. Name of the licensed independent practitioner(s) performing the procedure and any assistant(s)
B. The name of the procedure(s) performed
C. Description of the procedure(s)
D. Findings of the procedure(s)
E. Any estimated blood loss
F. Any specimen(s) removed
G. Postoperative diagnosis

When a full operative or high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note must be entered in the medical record before the patient is transferred to the next level of care.

It shall include:
A. The name of the Primary Surgeon and assistant(s)
B. Procedure performed
C. Description of each procedure finding
D. Estimated blood loss
E. Specimens removed
F. Postoperative diagnosis

The medical record for any operation or other high risk procedure must contain the following post-operation information:

A. The patient's vital signs and level of consciousness.
B. Any medications, including intravenous fluids and any administered blood, blood products, and blood components.
C. Any anticipated events of complications (including blood transfusion reactions) and the management of those events.

If applicable, the medical record contains documentation that the patient was discharged from the post anesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. The medical record contains documentation of the use of approved discharge criteria that determines the patient's readiness for discharge. The post-operation documentation contains the name of the licensed independent practitioner responsible for discharge.

XVIII. Discharge Summary is required for patients whose length of stay is 48 hours or more, or when death or transfer to another facility has occurred. It shall include:
A. Date of Admission and Date of Discharge/Death/Transfer
B. Reason for hospitalization
C. Significant findings
D. Procedures performed
E. The care and treatment and services provided
F. Patient's condition on discharge
G. Disposition at discharge
H. Specific instructions given to the patient and/or family as pertinent
I. Provisions for follow-up care

XIX. A Final Progress Note shall be written for those patients with problems and interventions of a minor nature who require less than 48 hours period of hospitalization. It shall include:
A. Outcome of the hospitalization
B. Disposition of the case
C. Provisions for follow-up care.

XX. Abbreviations, Signs and Symbols
A. Except for on the Face Sheet, Informed Consent Forms and Procedure Titles, signs, symbols and abbreviations that are listed in the most recent edition of *Steadman's Medical Abbreviations, Acronyms, and Symbols* book may be used in the medical record. This listing may be accessed via:
   1. Reference book in the Medical Records Department
   2. Online at http://www.steadmansonline.com
B. A list of **unapproved** or error prone abbreviations and dose designations are listed on the table below:

Official "Do Not Use" List

Do Not Use	*Potential Problem*	**Use Instead**
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "c"	Write "unit"
IU (International Unit)	Mistaken for IV 9intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.O mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write O.Xmg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write magnesium sulfate"
MR	Can mean Mitral Regurgitation or Mental Retardation	Write mitral regurgitation Write mental retardation

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

ATTACHMENTS:

I. Signature Log Sheet, Form #
II. GMHA Staff Signature Log Sheet

ATTACHMENT I

To be completed by all authors of entries into the medical health record.
This is to enable proper identification of the author.

Full Printed Name	Credentials	Signature as used in the Medical Record	Alternate form of signature or initial used in the Medical Record

Signature Log Sheet
Guam Memorial Hospital Authority
Approved Date: HIMC: 2/2015; MEC
GMHA Form # Stock #

PATIENT ID LABEL

ATTACHMENT II

GMHA STAFF SIGNATURE LOG

DEPARTMENT: _____

DATE: _____

COMPLETE NAME	POSITION TITLE	SIGNATURE # 1 (COMPLETE SIGNATURE)	SIGNATURE # 2 (ABBREVIATED SIGNATURE)	INITIAL

MEDICAL RECORDS DEPATMENT FORM

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

☐ Bylaws

☐ Rules & Regulations

■ Policies & Procedures

Submitted by Department/Committee: Medical Health Records Department

Policy No: A-RC 200

Title: Entries In The Medical Record

Rational for policy: Each medical record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

This policy will establish guidelines for the entries into the medical record, whether in paper or electronic format that comprises the medical record.

Reviewed/Endorsed	**Date**	**Signature**
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Reviewed/Endorsed	**Date**	**Signature**
Title	04/25/2016	Benita Manglona
	Name: Benita Manglona, CPA, CGMA ***Title:*** Chief Financial Officer	
Reviewed/Endorsed	**Date**	**Signature**
Title	04/29/16	
	Name: PeterJohn D. Camacho, MPH ***Title:*** Executive Management Committe Chairperson	