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POLICY: 200-050385-037

Completion of Medical Records Policy No. 615

Purpose
To establish standards, notification, and enforcement processes to ensure prompt completion of medical records by providers.

Policy
Harbor-UCLA Medical Center practitioners shall complete medical records in accordance with timeliness, data element, and legibility standards.

Procedure
Harbor-UCLA Medical Center policies shall be consistent with, and incorporate as necessary, all departmental policies and practices concerning date standards, as well as all licensure and accreditation requirements relating to the completion of medical records. At a minimum, each policy shall include specific requirements relating to the below defined standards.

Definitions

- **Attending or Attending Physician:** A member of the organized medical staff with privileges to perform patient care duties and are ultimately responsible for all aspects of the care of the patient.

- **Resident or Resident Physician:** Encompasses all categories of postgraduate trainees including physicians, dentists, and podiatrists enrolled in a training program. This includes interns, residents, fellows, and other postgraduate physicians. Resident physicians may be referred to collectively as housestaff.

- **Advanced Care Practitioners:** Certified Nurse Registered Anesthetists, Nurse Practitioners, Physician Assistants, Nurse Midwives.

- **Practitioner:** Any physician, dentist, or health-care professional including but not limited to Certified Registered Anesthetist, Certified Nurse Midwife, Registered Nurse Practitioner, or Physician Assistant.

- **Complete medical record:** All documentation in medical records, including all dictated information, shall be timely, accurate and complete. Clinicians providing patient care shall be responsible for preparing medical record documentation, which must include, but is not limited to the reason for the visit, admission and/or care; relevant history and physical examination findings; assessment, clinical impression and/or diagnosis, including the assessment of diagnostic test results; sufficient information/rationale to support the diagnosis/condition and to justify the medical necessity for admission, continued care, treatment and/or service; plan for care; evidence of patient informed consent, if required, description of therapeutic procedures performed, the patient's prognosis, response to treatment (including any complications), changes in treatment, and revision of diagnosis, if any, assess.

- **Incomplete medical record:** A medical record in which reports and signatures are not completed 14 days following the discharge date.

A. Standards

1. All required entries to a patient's electronic medical record shall he made as soon as possible following the date of the patient's visit, procedure, surgery, discharge, or death except in extenuating circumstances.
2. Specific medical record entries have been further defined in hospital policy and include: Admission History and Physical (Policy 608), Ambulatory Clinic notes (Policy 368), Consultation notes (Policy 360A), Emergency Room visit note, Death note (Policy 607), Discharge Summary (Policy 607), Procedure notes (Policy 609), and Progress notes (Policy 605) shall be dictated or entered into the electronic medical record immediately. **In no case shall entries be delayed for a period of more than 24 hours.**
3. Operative Reports (Policy 609) shall be entered into the medical record immediately upon completion of the case.

It is expected that all medical record entries will he completed with the required data elements as defined in the above referenced hospital policies by document and legible when applicable.

B. Procedures for Notification of Delinquent Medical Records

1. Medical records not completed by the end of the fourteenth (14) day, will be deemed delinquent by the Medical Records Department Staff.

2. A detailed delinquent medical record report will be e-mailed by the Medical Record Staff to the Chairperson and Program Director of each medical service weekly. This report will indicate which each physician on his/her service who has delinquent medical records, the type of delinquency, and the total number of delinquencies for that individual.

3. Health Information Management Director will report the total number of delinquent records monthly to the Health Care Information Committee, the Medical Executive Committee, the Chief Medical Officer, and the Program Director for resident physicians.

C. Procedures for Enforcement

1. The responsible practitioner for the delinquent medical records will be required to resolve the delinquencies immediately.

2. If unresolved after 10 calendar days, the resident will be placed on **"Suspension Without Pay"** until the delinquencies have been "cleared by the Medical Records Department. For medical record documentation that is the sole responsibility of an attending physician, the involved attending will have their elective and admitting clinical privileges suspended until the delinquencies are "cleared" by the Medical Records Department. This will constitute an administrative suspension.

3. Providers will be notified in writing 10 calendar days prior to the "Proposed Suspension" of delinquent status with no further notification. This communication will he copied to the respective Department Chair and Program Director.

4. Should the delinquent medical records be completed prior to the suspension start day, the suspension will be removed.

5. Any provider who is suspended without pay will have formal documentation of this disciplinary action in his/her portfolio and institutional file.

6. Any provider who receives **3** or more letters of "Proposed Suspension" within a 12-month period of time shall have a letter placed into their personal file by sending this document to the Department Chair for an attending physician or to the Program Director for a resident physician reflecting poor compliance with the competency of "Professionalism."

7. Any attending physician who has had their privileges suspended for a total of 30 days or more over a 12-month period is subject to Section 805 of the California Business and Professions Code reporting to the Medical Board of California.

D. Retiring of incomplete medical records

1. If a provider leaves HUMC permanently before completing medical records and can be contacted, Information Systems will be asked to reinstate the provider's electronic medical record access so that he/she may complete the records. Health Information Management will arrange access to the Electronic Health Record (EHR) using the External Reviewer process. This process limits EHR access to the incomplete records that are assigned to the provider.

2. If the provider who left Harbor-UCLA cannot be reached and an alternate provider can be identified, the record may be reassigned to the alternate provider for completion.

3. If the original provider is unreachable or an alternate provider who is willing to complete the medical records cannot be identified, the incomplete records will then be reviewed by Health Care Information Committee (HCIC). HCIC has the authority to remove the records from the incomplete status and deem them suitable for permanent record storage. At the front of the incomplete paper medical record, or as an addendum to the incomplete electronic document in the electronic health record, a statement to the effect below will be added: **"At the request of the Health Care Information Committee, this incomplete medical record has been filed in the permanent file. The provider is no longer practicing at Harbor-UCLA Medical Center and left prior to completing the patient's medical record."**

Reviewed and Approved by:

Medical Executive Committee - 0712016