NYGH POLICY & PROCEDURE

NUMBER: V-60

SUBJECT: **PHYSICIAN, DENTIST, AND MIDWIFE (CREDENTIALED STAFF) CHART COMPLETION**

CROSS REFERENCE:

DATE ISSUED: October, 2007
DATE REVIEWED:
DATE REVISED:

AUTHORIZATION:

PREAMBLE

Chart completion in compliance with the Public Hospital's Act is the responsibility of all Credentialed Staff involved in patient care. Health records are essential as a chronicle of the history of medical care and as a direction for future care. A patient's health record reflects the interactions between these staff and a patient, and may be used as legal documents.

POLICY

Each North York General Hospital credentialed staff member is responsible for documenting the portion of patient care that s/he has rendered as per the requirements of the Public Hospitals Act, Regulation 965 S. 19 (1-6). This policy is formulated to facilitate compliance with the Public Hospitals Act.

PROCEDURE

1.0 Health Information Management (HIM) will:

1.1 Ensure incomplete charts are available for completion within 7 days post discharge.

1.2 Review all In-patient Health Records to ensure each chart contains:
   a) An Operative Report, if applicable
   b) A Discharge Summary or Labour & Delivery Record for Obstetrics
   c) An Admission History and Physical Examination Report or Ontario Antenatal Record

1.3 Enter deficiencies into the Cerner system

1.4 Place incomplete charts in incomplete chart room

1.5 Notify credentialed staff of any records which are incomplete 14 days or more from the time they are available to complete.

1.6 Notify credentialed staff of any records which are incomplete 21 days or more allowing an additional 48 hours for completion.

1.7 Notify the Medical Directors and Program Chiefs of any credentialed staff who has not complied with completing records within 23 days from the time the chart became available for completion.

1.8 Once a month complete a full audit on a random sample of charts equal to 5% of the month's discharges to ensure compliance with other required components of the health record as set out in the Public Hospitals Act and Regulations.

1.9 Send a copy of the results of the random audit to the Medical Directors and Program Chiefs for their follow up.

In addition to the above and following the Ministry of Health and Long Term Care's deadline of May 31 for submitting coded data, HIM will file those charts which remain incomplete for the previous fiscal year into main filing system. HIM will notify credentialed staff 3 month prior to the closing date of May 31.

A letter signed by the Chair of the Medical Advisory Committee and CEO will be placed on the chart indicating non-compliance to chart completion policy by the credentialed staff member. A copy of this same letter will also be sent to credentialed staff office for inclusion in the member's credentialing file.

2.0 Credentialed staff will:

2.1 Ensure the documentation in the health record reflects the requirements of the **Public Hospital's Act, Regulation 965 S. 19(1-6)**

2.2 Ensure each admission history and physical, operative report and discharge summary contain the minimum requirements as per *appendix A*

2.3 Complete their charts at the time care is provided. To facilitate timely chart completion, **charts will remain on the unit 48 hours post discharge**

2.4 Check incomplete chart room on a regular basis and complete all outstanding charts within 14 days

2.5 Notify HIM of any extended time away from the hospital, such as vacation, illness

3.0 Medical Directors and Program Chiefs will:

3.1 Follow up with credentialed staff that has outstanding incomplete records greater than 21 days

3.2 Impose specific actions as appropriate for repeated failure to comply with chart completion

3.3 Notify the Manager of HIM of actions and expected time of completion of records

4.0 Enforcement of Policy:

4.1 Enforcement actions will be decided by each Medical Director or Program Chief and will reflect consequences appropriate to their clinical area.

4.2 In the event that records remain incomplete despite the above noted enforcement actions, the physician will be required to present before the Medical Advisory Committee for further review or disciplinary actions as deemed appropriate.

5.0 Potential Consequences:

Any one or more of the following consequences may be applied for non-compliance to chart completion policy:

- Obstetricians being taken off call for the delivery of their own patients until outstanding charts are completed in compliance with Hospital Policy.
- Loss of "one full day" of OR time. The penalty will be applied one month after the infraction to limit the impact on patients already booked and worked up for surgery. The OR time taken away will be given to another service. Repeat offenders during the same year will be given only 3 days grace period before penalty is enacted.
- Suspension of hospital privileges
- Call duties applied (extra weekend day or long weekend shift).

REFERENCES

- The Public Hospitals Act Regulation 965
- The College of Physicians & Surgeons of Ontario-Medical Records Policy #11-00
- Canadian Council on Health Services Accreditation (CCHSA) Standard 8.0.

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Appendix A

CHART COMPLETION POLICY
PHA Reg. 965 Section 19(1-6)

The minimum standard for a completed inpatient health record includes the following:

General Guidelines:

- All documents must be legible and written using black or blue ink
- Unapproved abbreviations should not be used
- Every entry must be authenticated and dated by the author
- Transcribed documents are strongly recommended

History and Physical

1. A History and Physical will be completed for all inpatients (includes medical, dental and midwifery examinations)
2. All History and Physicals will include:
    i. Identifying information (e.g. Author's name and status, name of most responsible physician, name of patient, Health record number, gender, date of birth, etc.)
    ii. Chief complaint and present illness
    iii. Past medical history, medications, allergies, family medical history
    iv. Physical examination and assessment
    v. Diagnosis
    vi. Treatment Plan

Operative Report

1. All Operative Reports will be completed for each patient for whom an operative procedure was performed.
2. All Operative Reports will be signed by the surgeon performing the procedure.
3. All Operative Reports will include:
    i. Identifying information (e.g. Author's name and status, name of most responsible physician, name of patient, Health record number, etc.)
    ii. Date of procedure

iii. Distribution copies (i.e. referring physician, family physician
iv. Pre-operative diagnosis
v. Proposed operative procedure (if different from procedure performed)
vi. Operative procedure performed
vii. Description of procedure performed
viii. Condition of patient during and at conclusion of operative procedure
ix. Post-operative diagnosis

Discharge Summary

1. A Discharge Summary will be completed for all inpatients.
2. All Discharge Summaries will include:
   i. Identifying information (e.g. Author's name and status, name of most responsible physician, name of patient, Health record number, Admission and Discharge dates, etc.)
   ii. Distribution copies (i.e. referring physician, family physician)
   iii. Brief summary of the management of each of the active medical problems during the admission; including major investigations, treatments and outcomes.
   iv. List of diagnoses, including the identification of most responsible diagnosis and pre-admit and post-admit comorbidities.
   v. Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment Follow-up instructions and specific plans after discharge, including outstanding tests and reports needing follow-up.