



## ESSENT HEALTHCARE, INC.

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| <b>Section: Corporate Compliance</b>                   | <b>Effective Date:</b> | <b>02/15/09</b> |
| <b>Subject: Medical Records</b>                        | <b>Revision Date:</b>  | <b>02/15/09</b> |
| <b>Policy #: CC-13</b>                                 | <b>Review Date</b>     | <b>11/19/09</b> |
| <b>Responsible Party: Corporate Compliance Officer</b> | <b>Revision #:</b>     | <b>1</b>        |

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**Scope:**

This policy applies to all Essent Hospitals and Physician Practices

**Purpose:**

The purpose of this policy is to set forth uniform standards for Medical Record Documentation.

**Policy:**

It is the policy of Essent that all medical records be completed in a timely manner and accurately reflect the treatment(s) provided to the patient(s) in accordance with medical staff by-laws. All information contained within the medical record is subject to HIPAA privacy and security regulations and shall be kept confidential at all times unless the record is being used for treatment, payment or hospital operations. For guidance on medical record privacy, please see the Essent *“Employee Guide to Privacy and Security”* which can be found on the corporate web site.

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**Procedure:**

- The complete medical record for each patient shall include the following:
  - A full medical history of the patient including chief complaint, details of present illness, relevant past social and family histories, and an inventory of body systems.
  - The history and physical report shall include a statement of the impressions drawn from the admission history and physical, and a statement of the course of action planned for the patient while hospitalized.
  - A comprehensive current physical assessment.
  - All diagnostic and therapeutic orders.
  - Informed consents.
  - Progress notes.
  - Special reports such as consultations, clinical laboratory reports, pathological findings, radiological and nuclear medicine reports, and anesthesia reports.
  - Reports of procedures, tests, and their results.
  - Nursing notes and entries by non-physicians containing pertinent observations and information.
  - Operative reports.
  - Discharge summary and follow-up (where applicable).



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- *Please refer to your medical staff by-laws for more specific guidance regarding medical record entries, authentication of medical record entries, and other medical record requirements.*
- Every entry in the medical record must include a complete date (month, day and year) and have a time associated with it. Time must be included in all types of narrative notes even if it may not seem important to the type of entry. Charting time as a block (i.e.7-3) especially for narrative notes is not advised. Narrative documentation should reflect the actual time the entry was made. For certain types of flowsheets, such as a treatment records, recording time as a block could be acceptable. For assessment forms where multiple individuals are completing sections, the date and time of completion should be indicated as well as who has completed each section.
- Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. If necessary to summarize events that occurred over a period of time (such as a shift), that notation should indicate the actual time that the entry was made with the narrative documentation identifying the time events occurred if time is pertinent to the situation.
- It is both illegal and unethical to pre-date or back-date an entry. Entries must be dated for the date and time that the entry is made.
- Every entry in the medical record must be authenticated by the author. This includes all types of entries such as narrative/progress notes, assessments, flowsheets, orders, etc. whether in paper or electronic format.
- When an error is made in a medical record entry, proper error correction procedures must be followed:
  - Draw a line through the entry. Make sure that the inaccurate information is still legible;
  - Initial and date the entry;
  - State the reason for the error;
  - Document the correct information. Do not obliterate or otherwise alter the original entry by blacking out with marker, using white-out, or writing over an entry.
- At times it will be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement or clarify previously written entries. When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical



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record:

- 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 written on a previous date or at an earlier time;
  - Identify or refer to the date and incident for which the late entry is being written;
  - If the late entry is used to document an omission, validate the source of additional information as much as possible. For example, use supporting documentation on other facility worksheets or forms;
  - When using late entries document as soon as possible. There is no time limit for writing a late entry, however, the more time that passes the less reliable the entry becomes.
- An addendum 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 incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum:
    - Document the current date and time;
    - Write “addendum” and state the reason for the addendum referring back to the original entry;
    - Identify any sources of information used to support the addendum;
    - When writing an addendum, complete it as soon after the original note as possible.
  - Another type of late entry is the use of a clarification note. A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted. To make a clarification entry:
    - Document the current time and date;
    - Write “clarification” and state the reason and refer back to the entry being clarified;
    - Identify any sources of information used to support the clarification;
    - When writing a clarification note, complete it as soon after the original entry as possible.
  - **It is considered willful falsification and illegal to go back and complete or fill in “holes” on medication and treatment records or other graphic/flow records. When missing or incomplete documentation is identified, it is Essent policy to use addendums or late entries to complete or clarify medical record information. When there is total recall by the provider, and other supporting documentation, late entries may be made within 72 hours of the treatment or event that requires clarification. Entries made later than 72 hours after the incident or treatment must be made via an addendum or clarification to the record.**



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### References:

American Health Information Management Association Guidelines (AHIMA)  
Medical Staff By-laws