**Policies and Standards**

**SECTION:**
Health Record Documentation

**NO.:**
EHR-02

**CHAPTER:**
Record Documentation

**ISSUED:**
Jan 2011

**REV. A**

**POLICY:**
Timely Completion of Health Records

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**PURPOSE**

A patient’s health record must reflect accurate documentation, timely completion, and accessibility.

**POLICY**

In an effort to reduce the potential of adverse patient events due to inaccurate and incomplete health records, timeliness guidelines have been created and will be followed by all providers and staff.

**SCOPE**

This policy applies to all CMA providers and staff.

**PROCEDURES**

1. **EHR Documentation - Patient Appointment:** The following outlines the expectations for electronic health record (EHR) documentation completion:
   
   a. **Provider Notes** – All notes must be signed off and the encounter form submitted within 7 business days of the patient encounter
      
      i. The note must be signed off before the encounter form is submitted
   
   b. **Provider Orders** – All orders must be entered in the EHR before the patient leaves the clinic
   
   c. **Point of Care (POC) Lab Result Entry** – Results must be entered in the EHR no later than the end of the provider’s clinic session(s) the day of the patient encounter; preferably before the patient leaves the clinic
   
   d. **Medication Administration** – Medication administration must be documented in the EHR no later than the provider’s clinic session(s) the day of the patient encounter; preferably before the patient leaves the clinic
   
   e. **Immunization Administration** – Immunization administration must be documented in the EHR no later than the provider’s clinic session(s) the day of the patient encounter; preferably before the patient leaves the clinic
f. *Referral Scheduling* – Referrals must be initiated within 1-3 business days based on priority

g. *Financial Authorization* – Financial (insurance) authorizations must be initiated within 2 business days of the order

h. *Schedule Follow-Up Appointment* – Patients should be asked to schedule a follow-up appointment before leaving the clinic. If the patient requests to wait, the patient will be contacted within 5 business days to schedule the follow-up appointment

i. Exception – Patient refusal

ii. If the clinic schedule is not available, a reminder order for the follow-up appointment will need to be entered in the EHR

2. **EHR Documentation - Non-Appointment:** The following outlines the expectations for electronic health record (EHR) documentation completion:

   a. *Medication Renewals* – Renewals must be completed within 48 hours from receipt of the electronic prescription request (SureScripts) or the pharmacy fax

   b. *Verification of Patient Results* – Patient results will be verified within 3 business days within receipt of the results.

   c. *Return Patient Calls* – Patient call-backs will be initiated within 1 business day and each attempt will be documented on the task request.

   d. *On-Call Coverage*—Providers responding to a patient request outside normal office hours, will document that action with an ad hoc telephone note, copied (or tasked) to the patient’s provider within 1 business day.

3. **Non-EHR Documentation:** For those clinics not on the EHR, patient visit dictation/note and charge ticket must be completed, signed, and sent to the referring provider within 7 business days of the patient encounter

   a. Prescription refills will be completed in 2 business days

   b. Return patient calls will be completed in 1 business day

4. **Inpatient Records:** Inpatient records will be completed as directed by hospital policy
5. **Reporting/Auditing:**

   a. Monthly reports will be distributed to the service line directors, clinic managers, and providers to track the timeliness of provider note documentation
      
      i. The Service Line Director will notify the Department Chairman/Division Chief regarding those providers who do not meet the 7 business day note and encounter form documentation guidelines for timely resolution.

   b. The Clinic Managers will review or spot check the staff and providers task lists daily for timeliness

   c. Quarterly audits will be conducted by the CMA Quality Office to track the timeliness of the clinical support staff daily documentation (see #1c-g) in the EHR. The data will be distributed to the Service Line Directors and Clinic Managers.

   d. Clinic support staff who do not meet the documentation guidelines will be counseled by the clinic manager; further non-compliance may result in disciplinary action in accordance with University procedures.

**ADMINISTRATION AND INTERPRETATIONS:** This policy shall be administered by the CMA Quality Office. Questions regarding this policy should be directed to the Quality Director at 280-5848, or via email at cmagilityoffice@creighton.edu.

**AMENDMENT/Termination of This Policy:** Creighton Medical Associates (CMA) reserves the right to modify, amend or terminate this policy at any time. This policy does not constitute a contract between the CMA and its employees.

**Exceptions:** None

**Violations/Enforcement:** Any known violations of this policy should be reported to the CMA President at 280-4087 or via e-mail to cmapresident@creighton.edu. Violations of this policy can result in disciplinary action in accordance with University procedures.