

Completion of Records of Personal Health Information (PHI)		
For Policy Office Use Only		
☒ Administrative ☐ Clinical	Policy Number: 10331	
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Policy Sponsor: VP Quality, Strategy & Family Partnership
Scope/Impact: CHEO medical staff completing clinical documentation for Inpatient, Emergency, Anesthetic or Operative care.
Keywords: Patient records, Health records, chart completion, chart deficiency, Health Information Management

See Writing Guidelines in the Policy Toolkit for definitions and tips on how to complete this template.

1. PURPOSE:

To ensure the timely completion of patient records of personal health information (PHI) in accordance with the Public Hospitals Act, CHEO Medical By-Laws, Canadian Institute of Health Information (CIHI) chart abstraction and coding requirements, and applicable professional regulatory colleges. This policy focuses on the timelines of documentation completion, the required content of specific documentation types, as well as the monitoring, notification, escalation and consequences for instances where documentation has not been completed within the expected timelines or content requirements.

2. POLICY:

- 2.1 All clinical documentation of patient care will be completed in compliance with the Documentation Policy (#361).
- 2.2 The following documentation completion timelines shall apply, recognizing different timelines by encounter and document type. "Completion" implies that the document contains the minimum required content and has been fully signed by the author and co-signed by the supervising staff member, if required. These timelines are automatically tracked in Epic, and incomplete documentation is flagged to staff members through their Epic InBasket:
 - a) Inpatient Admission Note (i.e., Admission history & physical exam) – completed within 24 hrs of the Decision to Admit, which corresponds to the bed request order in Epic
 - b) Inpatient Discharge Summary – completed within 48 hrs of the patient's departure from the hospital, transfer to another health care organization, or death. For transfers, the Discharge Summary should ideally be completed prior to departure to be part of the information accompanying the patient.
 - Note: All Inpatient admissions, irrespective of their duration, reason or complexity, require a discharge summary; the only exception is for patients being admitted from the Emergency Department where the patient's condition improves before the patient is transferred upstairs and before the Inpatient physician assumes responsibility for the patient. In cases where the patient has remained the responsibility of the Emergency Physician, they will add a clear reassessment note to the Emergency Department Summary of Care identifying the rationale for cancelling the admission and the patient's pertinent physical exam findings on discharge, along with a revised disposition plan.
 - c) Emergency Department Summary of Care – completed within 72 hrs of the patient's departure from the ED.
 - Note: For admitted patients, the documentation must be completed before the ED physician leaves their shift, and if possible before the patient is transferred to the floor. For patients who die in the ED, their documentation must be completed before the ED physician leaves their shift.

- d) Inpatient or Emergency Department Consultations – documentation must be initiated with the preliminary assessment and recommendations to reflect the verbal review a trainee has with the attending medical staff consultant, and then must be completed and cosigned within 72 hours of the consultation request.
 - Note: Where the consultation note is being referenced as the Inpatient Admission Note, the consultation must be completed within 24 hrs of the Decision to Admit.
- e) Anesthetic Records – completed within 72 hrs of the patient's departure from the operating room, procedure room or Medical Imaging suite.
- f) Day Surgery Pre-operative History & Physical – completed within 24 hrs of the patient's procedure, recognizing that this document may reflect the general assessment completed in the past when the procedure was planned, and then augmented with pertinent history or physical exam findings identified prior to the procedure.
 - Note: Patients who come in for same-day procedures where there is a plan to admit them to hospital post-procedure also require an Inpatient Admission Note, which can simply reference the Day Surgery Pre-operative History & Physical.
- g) Operative Note – A brief operative or procedure note must always be documented at the end of the procedure to bridge until a full operative or procedure note can be completed, unless the full procedure note can be completed before the patient leaves the procedural area (or Post-Anesthetic Care Unit). Otherwise, the full operative note must be initiated within 24 hrs of the procedure and completed within 72 hrs.
- h) Outpatient consultations or follow-up encounters – completed within 7 days of the encounter. Communication (i.e., external letters or InBasket communication) should be routinely sent to the relevant providers requesting consultation or co-caring for the patient, following each encounter.

2.3 All verbal orders must be cosigned by the individual making the verbal order request (i.e. Ordering Provider) within 24 hrs of it being documented in Epic (see Verbal and Telephone Order Policy #PHA-9), after which it becomes deficient. Verbal order deficiencies get manually escalated to the Authorizing staff physician for co-signature when the relevant encounter documentation is quantitatively analyzed, or if the Ordering Provider has left CHEO.

2.4 Health Information Management coding staff complete quantitative and qualitative analysis and translate clinical documentation into appropriate ICD-10-CA and CCI codes for submission to CIHI. Standards for the minimum content to be included in each document is summarized in Appendix A. Completed documentation that is missing key information will be returned to the appropriate medical staff for correction using a Coding Query sent through Epic InBasket. If not responded to within 10 days, coding staff will follow-up by email or telephone. Coding queries that remain unresolved after 21 days will be considered deficient.

2.5 Documents that have exceeded the completion timelines outlined in Sections 2.2, 2.3 and 2.4 will be considered deficient. Chart deficiencies are tracked in the Epic Health Information Management (HIM) module (except Outpatient consultations and follow-up encounters). Weekly automated email reminders are sent to the staff member and appropriate supervisors, as follows:

- a) Level One – to the medical staff member when one or more documents becoming deficient. As the automated reminders come out weekly, the deficiency may be 0-6 days old when the reminder is triggered.
- b) Level Two – to the medical staff member and their Division Chief (Department Chief where there is no Division Chief) if one or more Level One deficiencies remain deficient a further 7 days (now between 7-13 days following becoming deficient).
- c) Level Three – to the medical staff member, their Division Chief (if applicable), their Department Chief and the Medical Staff Office (Chief of Staff) if one or more Level Two deficiencies remain deficient a further 7 days (now between 14-20 days following becoming deficient).

- d) Ongoing or repeated Level Three deficiency situations can be grounds for the Chief of Staff to suspend hospital privileges until the deficiencies are completed. Suspension of privileges obligates the Chief of Staff to notify the appropriate regulatory college. The Department Chief may also impose financial or other sanctions, at their discretion, within their practice plans.

2.6 Medical Staff are encouraged to notify the Health Information Management department of any absence from the hospital greater than 1 week so that new or existing documentation requirements do not become deficient or progress to higher levels during their absence. This notice must be made in advance of the absence and cannot be made retroactively. Medical staff are encouraged to clear all existing documentation queues prior to their departure. If a medical staff member is already at Level One or higher, Epic will continue to produce automated weekly notifications for the existing level to the medical staff member and relevant supervisors, despite the recorded absence, which will only prevent the level from progressing.

3. RESPONSIBILITIES:

3.1 Health Information Management staff are responsible to:

- Assist medical staff and those documenting on their behalf
- Manage the Epic HIM module, monitor relevant documentation completion queues, and ensure deficiency notifications are sent
- Complete quantitative and qualitative analysis of relevant clinical documentation against documentation standards; in response to missing content, generate Coding Queries to the appropriate member of the medical staff
- Receive and record hospital absences for members of the medical staff

3.2 Medical Staff are responsible to:

- Provide clear expectations to trainees on clinical documentation standards, content and timelines, as well as the need to sign verbal orders as soon as possible
- Complete and cosign all clinical documentation (as required) within the standards for content and timelines
- Escalate documentation issues or difficulties to the Epic Helpdesk to allow timely resolution and completion
- Respond to Coding Queries or seek clarification from coders in a timely manner, within completion timelines
- Notify the Health Information Management department of absences from the hospital

3.3 Medical Leaders are responsible to:

- Promote completion of all clinical documentation within the standards for content and timeliness
- Monitor documentation completion reports and deficiency notifications
- Collaborate with and coach individuals on how to improve their clinical documentation content and timeliness
- Apply consequences or sanctions, as appropriate, for staff members who have ongoing or recurrent deficiencies

4. PROCEDURE:

4.1 Most aspects of monitoring documentation completion are automated within the Epic system, including the creation of the documentation requirements within InBasket following the creation of the relevant encounter or procedure, as well as the notification of outstanding deficiencies.

4.2 Health Information Management staff monitor the system and also complete manual quantitative and qualitative analysis of documents to identify deficiencies. These are manually added to the system, and the relevant medical staff are notified through a Coding Query.

4.3 The Epic HIM module automatically notifies medical staff with Level One, Two or Three deficiencies, using the email on file, according to the timing outlined in Section 2.4. Divisional/ Departmental/Hospital reports are sent to Medical Leaders.

4.4 In the event the Chief of Staff decides to suspend privileges for a medical staff member with ongoing or repeated Level Three deficiencies, the Chief of Staff will:

- Provide written notification to the medical staff member, as outlined in CHEO Medical Staff By-Laws
- Notify the Department and Division Chiefs to ensure that provisions are made to care for existing patients and cover upcoming on-call duties
- Notify relevant operational directors and medical directors, including eHealth, Admitting and Patient Registration, the Emergency Department and the Operating Room (if applicable).
- Notify the appropriate regulatory college.

5. CROSS-REFERENCES:

- Documentation Policy
- Verbal and Telephone Order Policy

6. REFERENCES:

- Ontario Public Hospital's Act
- CHEO Medical Staff By-Laws
- Canadian Institute for Health Information

7. APPENDICES:

- Appendix A – Quantitative and Qualitative Documentation Standards

DEFINITIONS:

Deficiency: refers to a required document or documentation step that remains incomplete, considering the content standards and completion timelines appropriate for the document type and encounter.

Qualitative Analysis: refers to review of documentation within the electronic health record to ensure that the content of each document satisfies the requirements for coding abstraction and submission (i.e., each discharge summary includes the relevant dates and all diagnoses, etc.).

Quantitative Analysis: refers to review of documentation within the electronic health record to ensure that the appropriate document types for the care provided exist (i.e., each admission has an admission note and discharge summary).

Version History:

Date (DDMMYY)	List of minor revisions	List of major revisions

Appendix A: Quantitative and Qualitative Documentation Standards

Each document type has specific components that are required to be present for coding and abstraction purposes, as well as to adequately communicate to other providers.

Inpatient Admission Note (i.e., Admission history & physical exam)

Must be completed within 24 hrs of the Decision to Admit, which corresponds to the bed request order in Epic

Document must include:

- Admitting staff and service
- History, physical examination, recent investigations or assessments
- Diagnoses or provisional diagnoses
- Reason for admission and plan for investigation and treatment

Note: In the event that a consultation completed in the Emergency Department or an outpatient setting leads to admission, that note can be referenced and serve as the admission note, providing it contains all required components. Please use the following format: “Please see details in the ED Consultation note from dd/mm/yyyy written by Dr. _____.” Similarly, the Day Surgery Pre-Operative History & Physical Exam can be referenced as the Inpatient Admission Note if the patient requires an unplanned admission following their procedure, but the circumstances leading to the admission should be added along with any update to the patient’s physical condition on admission.

Inpatient Discharge Summary

Must be completed within 48 hrs of the patient’s departure from the hospital, transfer to another health care organization, or death. For transfers, the Discharge Summary should ideally be completed prior to departure to be part of the information accompanying the patient.

Document must include:

- Admission and discharge dates
- Admitting diagnoses
- Brief review of the presentation, physical findings and investigations leading to admission
- Course in hospital, including any complications, reactions or unplanned escalations or deviations in the care plan
- Concise summary of key investigations and consultations. Do not copy entire diagnostic results or consultation notes.
- All discharge diagnoses known or presumed at the time of discharge, beginning with the most responsible diagnosis contributing most to the patient’s length of stay and/or resource utilization (Principal problem)
 - Note: The Principal Problem must be indicated within the Epic Problem List for the inpatient encounter. Failure to choose a Principal Problem is considered a chart deficiency
- Discharge medications and treatments
- Follow-up plans, including involvement of Home & Community Care, Children’s Aid, or other factors impacting the patient’s disposition

Note: All Inpatient admissions, irrespective of their duration, reason or complexity, require a discharge summary; the only exception is for patients being admitted from the Emergency Department where the patient's condition improves before the patient is transferred upstairs and the Inpatient physician assumes responsibility for the patient. In these cases, a clear reassessment note will added to the Emergency Department Summary of Care identifying the rationale for cancelling the admission and the patient's pertinent physical exam findings on discharge, along with a revised disposition plan.

Note: In the event of a patient death while in the Emergency Department or admitted to hospital, the Emergency Department Summary of Care or Impatient Discharge Summary should include the following additional elements, as relevant, by using an appropriate template:

- Date and time of death
- Preliminary cause(s) of death
- Course leading up to pronouncement of death, including all resuscitative procedures
- Notification of the coroner, their name, and decision about accepting the case
- Notification to Trillium Gift of Life Network and decision about organ/tissue donation
- Plans for autopsy
- Notification to primary care provider and others involved in the patient's care
- Documentation that the death certificate has been completed and by whom

Operative Note

A brief operative note must always be documented at the end of the procedure to bridge until a full operative note can be completed, unless the full procedure note can be completed before the patient leaves the procedural area (or Post-Anesthetic Care Unit). The full operative note must be initiated within 24 hrs of the procedure and completed within 72 hrs.

Document must include:

- Date of the procedure
- Name of surgeon/proceduralist, assistants and anesthesiologist
- Pre-operative diagnosis
- Post-operative diagnosis
- Listing of all procedures performed
- Comprehensive description of each procedure, including:
 - Technique or approach
 - Intra-operative findings
 - Specialized equipment used
 - Hardware, devices or materials implanted
 - Intra-operative complications
 - Any issues with sponge/instrument counts
- Post-operative condition and plan

Note: If more than one service is involved in an operation, each service is required to generate their own operative note.