Texas Health Southlake Medical Records Documentation Timeline Completion

Document Type	Details	Timeframe to Complete
History and Physical	• All practitioners are to document a complete medical history and physical examination (H & P) for all patients no later than 24 hours after admission but prior to surgery or any procedure requiring General anesthesia or moderate sedation. • If a complete H & P has been recorded within 30 days prior to admission or surgery a durable legible copy of this report in a form approved by the Medical Staff and performed by a Member of the Medical Staff, may be used in the medical record for the current admission or surgery. The H & P must be updated not later than 24 hours after admission but prior to surgery, by documenting patient examined, H&P reviewed, no significant changes or listing changes in the patient's condition.	**H&P completed within 30 days can be used**, but **must be updated** prior to the patient going back to surgery. If no H&P is present or **greater than 30 days**, a **new H&P must be completed** prior to surgery.
Immediate Post-Operative Note	• If a complete operative report is not placed in the medical record immediately after surgery, a postoperative progress note, comprehensive enough to permit continuity of care, including all required elements listed below, must be entered in the medical record at the time of completion of the procedure and prior to the patient going to the next level of care. • The post-operative progress note shall include: o the name(s) of the primary surgeon(s)and his or her assistant(s) o procedure performed and a description of each procedure o findings o complications (if any) o estimated blood loss o specimens removed o postoperative diagnosis Utilize one of the THR CareConnect note templates to ensure all required elements are included. CareConnect Templates are: MD IMMEDIATE POST PROCEDURE PROGRESS NOTE or MD IMMEDIATE POST OPERATIVE PROGRESS NOTE.	**Immediately after surgery** and prior to the patient going to PACU.
Operative Report	• Complete operative reports must be completed in CareConnect or dictated in the medical record within 24 hours after surgery and shall contain: • The name of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s) • The name of the procedure(s) performed; • A description of the procedure • Findings of the procedure • Any estimated blood loss • Any specimens removed	Must be dictated **within 24 hours** after surgery.

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	• Complications, if any • The postoperative diagnosis	
Progress Notes	• The progress notes should provide a chronological report of the patient's course in the hospital and should reflect any material change in condition and the results of treatment. • The patient's clinical problems should be clearly identified and correlated with an assessment and plan. • Progress notes shall be legible, dated, timed and signed.	Progress notes shall be documented **at least daily** and more often when warranted by the patient's condition.

Discharge Summary	• A discharge summary shall be entered or dictated for patients admitted to the hospital.
	• In the event a patient is seen for minor problems or interventions and is hospitalized less than 48 hours, a final progress note may be substituted for the discharge summary and must include outcome of hospitalization/disposition of the case, final diagnosis and pertinent instructions/provision for follow-up care to the patient or family.
	• The discharge summary shall include the following:
	  • the reason for hospitalization;
	  • a summary of the care, treatment, and services provided;
	  • a summary of all consultations;
	  • procedures performed;
	  • the patient's condition and disposition at discharge;
	  • final diagnosis
	  • any complications
	  • Information provided to the patient and family
	  • Provisions for follow-up care
		If patient is hospitalized **less than 48 hours**, a **final progress note will be sufficient.**
		
		Greater than 48 hours requires a **full discharge summary.**

Orders	• Telephone orders will be accepted with read back order mode, entered within the EHR and signed by responsible practitioner within 48 hours after given. • Verbal orders are not a preferred method of ordering, but in specific situations such as emergencies or provider inability to enter the order due to direct involvement in patient care (Example: performing a sterile procedure), verbal orders are acceptable with read back order mode, entered within the EHR and signed by responsible practitioner within 48 hours after given. • All orders shall be authenticated in the medical record by the ordering practitioner. • For each medication, the administration times or the interval between doses must be clearly stated in the order.	Must be signed **within 48 hours.**

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Entire Record	• All patient records must be completed within thirty (30) days of patient discharge. • If medical records of a practitioner are delinquent, the practitioner's clinical privileges may be suspended until the deficiency is corrected. The practitioner shall not be entitled to a hearing if suspended for deficient medical records. • Should illness or absence prevent a practitioner from completing his/her records consistent stated timelines the practitioner should notify the HIM Department. An extension may be granted not to exceed the length of the illness or absence. • If on suspension because of delinquent records the practitioner shall not be permitted to schedule new admissions and/or surgery, but shall be allowed to provide continued care to current inpatients and patients already scheduled for non-elective surgery or to provide care in the case of an emergency.	Entire record should be **completed within 21 days**. Practitioner **may be suspended** if records are **incomplete past 30 days**.