Southeast HEALTH

Documentation Requirements – Report Contents

For complete instructions, refer to Rules & Regulations Articles II – VI

All records must be dated, timed, and authenticated

Operative Reports - immediately after procedure/surgery; before patient transitions to the next level of care

1. Name of specific surgical procedure(s) performed
2. Name of primary surgeon(s) and any assistant(s)
3. Description of procedure(s) performed
4. Findings of each procedure performed
5. Complications, if any
6. Estimated blood loss, if applicable
7. Any specimen(s) removed
8. Prosthetic devices or implants if used, if any
9. Post-operative diagnosis

Discharge Summary- within 30 days of discharge

1. Discharge diagnosis
2. Reason for hospitalization
3. Significant findings
4. Procedures performed and treatments rendered
5. Condition of patient and discharge
6. Instructions to include activities, diet, medications, and provision for follow-up care
7. For stays less than 48 hours, the final progress notes may serve as the discharge summary if they contain the same elements

History & Physical – in record within 24 hours of patient admission

1. Chief complaint
2. History of present illness
3. List of allergies
4. List of current medications or attest to the accuracy of the medication reconciliation document
5. Relevant review of body systems
6. Relevant past, social and family history
7. Relevant physical exam
8. Impression
9. Plan of care
10. If indicated, information necessary to prevent harm to other patients or to the Hospital' s employees or other medical providers if the physician reasonably believes that the patient poses a risk of harm to others

Consultation Report

1. Review of findings
2. Examination of patient and patient ' s medical record
3. Recommendations made
4. Impression

Downtime/Paper Chart Entries

1. Entries made on paper must be signed, dated, and timed
2. Correct handwritten errors: single line through entry; write 'error' with initials, date, and time

BEST PRACTICES FOR EXCELLENT DICTATED HEALTHCARE DOCUMENTATION

The ultimate goals of healthcare documentation are to:

- Improve patient care documentation and the effectiveness of communication among caregivers
- Promote patient safety initiatives
- Ensure appropriate hospital/provider reimbursement for services rendered
- Promote compliance with privacy and security regulations
- Ensure accurate charting of patient treatment provided
- Reduce turn-around time from the completion of dictation to availability of the finalized document on the patient's chart
- Ensure uncompromised dictated reports as legal documents

To assist in achieving these goals, the following dictation best practice tips are recommended:

1. Dictate in confidential areas away from distractions and noise; avoid speaker phones and cell phones; avoid eating, chewing gum, or sucking on hard candy while dictating.
2. Dictate as soon as is possible following the treatment provided to improve accurate and complete capture all services provided.
3. Enter accurate keypad prompts: physician ID, patient ID, worktype.
4. Speak in a normal conversational voice, clearly annunciating new or unfamiliar terms and sound-alikes (BMP vs BNP, abduction vs adduction, etc.).
5. Dictate accurate identifying information in case it was accidentally miskeyed: provider's name, patient name (spell uncommon names or spellings), patient identifiers (ideally at least two to assure correct patient identification – MRN, DOB, etc.), type of report, treatment or admit/discharge dates.
6. Avoid overuse of abbreviations and use of Joint Commission DO NOT USE abbreviations.
7. Dictate all needed information to promote complete and accurate healthcare documentation and excellent patient care through improved communication (see other side for suggestions).
8. Indicate end of dictation and write down provided job number from dictation system.
9. Every report should have its own dictation.
10. Use of stat/priority keypad prompt should be reserved only for those times.

Rationale for utilizing standardized dictations:

- Improve the quality of healthcare documentation and communication among providers
- Improve capture of all elements required by CMS or needed to code accurately under ICD-10
- Dramatically decrease amount of time spent dictating