Contents of the Patient Record

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This lecture is continued from Learning Unit 5.

The next form is the **history and physical examination** or many times referred to as the H&P. Several reference materials separate the history and physical into separate forms, but most facilities combine them into one report. I am going to reference them as one report as this is how I have always dealt with them in the facilities that I have worked in the past.

The time frame for the history and physical for both the Joint Commission and Medicare COP is that the H&P must be performed and documented in the patient's record within 24 hours after admission for acute care inpatients. The H&P may also be completed 30 days prior to the admission.

So let's discuss the requirements for the contents for the history portion –

The first is the chief compliant, which is also known as the CC. Yes we have already discussed CC's when we talked about complications and comorbidities, so this is another CC. The chief compliant should be in the patient's own words, such as "I think I am having a heart attack." The second portion is the history of present illness which is known as HPI, this includes the patient's current illness. The third section is the past/family/social history; this section is known as PFSH. The final section is the review of systems, which is known as ROS; it includes an inventory of body systems.

The next area is the physical exam which includes a general survey of the body systems and impression. This helps in the creation of the provisional diagnosis. Remember the provisional diagnosis is made upon admission without any further study. The provisional diagnosis may include a differential diagnosis. The differential diagnosis may indicate that several diagnoses are being considered**.**

Another history form that you will see is the **interval history**. An interval history may be used if the patient is readmitted within 30 days with the same condition.

The next report is the **consultation report**. This report consists of a consulting physician whose opinion or advice is requested by another physician. The report is documented by the consultant and includes the consultant's opinions and findings based on a physical examination and review of patient records. This is important to note, consultations are required on critically ill patients who are poor surgical risks, and those whose diagnosis is difficult or obscure.

Let's move onto **physicians orders** which are also known as doctor's orders. The physician is responsible for ordering all diagnosis and therapeutic care activities. In order for these services to be completed there must be a physician order on the chart. The physician is required to sign and date each order. An example of special physician order is called a **standing order**. This order is pre-approved by the medical staff that directs the continual administration of specific activities for a specific period of time. Also, many times the physician is not at the hospital and the nurse will call the physician regarding the

patient's condition. If the physician makes an order over the phone it is referred to as a telephone order, also known as a TO. The nurse will document the order in the chart, but the nurse must read and verify the order back to the physician to clarify the order. There are several types of physician orders, these include: discharge order, routine order, automatic stop order, and transfer order. The physician must sign the order upon returning to the hospital. All orders must be dated, timed, and signed by the physician.

Another important form is the **progress note**. Progress notes serve as a communication tool for all health care team members. The utilization review department reviews and evaluates the patient's progress to justify the patients stay. Progress notes must document the course of the patient's illness, response to treatments, and status at discharge. There are numerous types of progress notes, these include: admission notes, follow-up, discharge note, case management note, dietary note, rehabilitation therapy progress note, respiratory therapy progress note, pre and post anesthesia evaluation note, pre and post-operative note. An integrated progress note is a note that allows all health care providers to document on one form.

We will now briefly discuss the **anesthetic record**. Medicare COP requires documentation of a pre-anesthesia note by an individual qualified to administer anesthesia within 48 hours prior to surgery. The time frame for the post-anesthesia note is 48 hours after surgery.

The next form is the **operative record**. This report should include a description of the procedure performed. The operative report must be documented immediately after surgery. It is a requirement that surgeon include a preoperative and postoperative diagnosis on the operative report.

A **pathology report** is required whenever tissue or other material is removed from the patient. This report can also be called a tissue report. A physician referred as the Pathologist is responsible for documenting a descriptive diagnostic report. The pathological diagnosis will include grade, histology, and stage.

There numerous types of **ancillary reports**. As we noted earlier in this lecture, the physician must complete a physician order, to order ancillary testing such as lab and x-ray. Once the test has been completed the documentation of the report must be filed within the patient record.

When you think about who really takes care of you when you are the hospital – it is the nurses. Nurses never get the credit they deserve. Nursing documentation plays a crucial role in patient care. As a general rule, nursing documentation includes the following:

- Nursing care plans which document nursing interventions to be used to care for the patient
- Nursing notes that documents daily observations about the patient, including an initial history of the patient, patient's reactions to treatments, and treatments rendered
- Nursing discharge summary which documents patient's discharge plans and instructions
- The medication administration record, also known as the MAR, which documents medications administered to the patient

- The graphic sheet that documents the patient's vitals, also called TPR, which stands for temperature, pulse, and respiration

Now let's move on to the mom and baby charts. The mother chart is referred to as the **obstetrical record**. The moms chart is divided into three sections. The first section is the antepartum record which is also referred to as the prenatal record. The prenatal record begins at the obstetrician's office. A copy of the antepartum record is sent to the hospital by the 36th week of pregnancy. The second section is the labor and delivery record. This record is from the time of admission through time of delivery. And finally the third section is the postpartum record which summarizes the mother's condition after delivery.

The **neonatal record** is also referred to as the newborn record. The newborn record includes: birth history, newborn identification, newborn physical exam, and newborn progress notes. The newborn history is a summary of pregnancy, as well as the labor and delivery and condition of the newborn at birth. The newborn identification of course includes the footprints, fingerprints, and wrist and ankle bands for the mother and baby.

The **APGAR score** is a general indication of the infants health at one minute and five minutes after birth.

The next report is the **autopsy report** which is also called necropsy report or the postmortem examination. The Joint Commission standard states that the provisional diagnosis be documented in the patient's record within 72 hours after an autopsy is performed. The final report should be filed within the record within 60 days. Prior to performing an autopsy, consent must be obtained from the legal next-of-kin, and the signed consent becomes part of the patient record (unless it is a coroner's case). It is important to note that an autopsy is required for the following circumstances:

- Any case where there is a medical or legal necessity
- Cause of death is not related to treatment
- Dead on arrival to ER or dying in ER without previous diagnosis or definitive diagnosis
- Sudden infant death
- Trauma (internal)
- Pediatric and prenatal deaths
- Occult hemorrhage
- Pneumonia

Most of the previous forms that we discussed this far included those for inpatient records. Now, let's focus our attention to outpatient records. The **Uniform Ambulatory Care Data Set (UACDS)** is the minimum core data set collected on Medicare and Medicaid outpatients. Terms to be familiar with for the outpatient setting include:

An outpatient visit is defined as a visit of a patient on one calendar day to one or more hospital departments for the purpose of receiving outpatient health care services.

An encounter is defined as a professional contact between a patient and provider who delivers services or is professionally responsible for services delivered to a patient.

An ancillary service visit or occasion of service is defined as the appearance of an outpatient to a hospital department to receive an ordered service, test, or procedure.

The **physician's office record** typically will include patient registration information, a problem list, a medication records, progress notes, and results of ancillary reports. The **encounter form** which can also be referred to as the superbill or fee slip is used to capture charges generated during the office visit. This form consists of a list of common services provided at the office.

The last portion of this discussion is on forms control and design. The forms committee is established to oversee the process and to approve forms used in the record.

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