ELMHURST OUTPATIENT SURGERY CENTER

POLICY/PROCEDURE:	**Medical Record Documentation Timeliness**	**EFFECTIVE DATE:**	**1/2/2011**
SECTION:	**Information Management**	**LAST REVISION:**	**12/6/10; 8/21/12; 2/18/13**

OBJECTIVE

To ensure timely entry of documentation into the medical record based on CMS and Joint Commission standards.

PLAN COMPONENTS

Procedure Note
A Procedure Note must be completed on the date of service at the Surgery Center by the performing surgeon. This note serves as the record of the patient's procedure until the Operative Report is dictated, transcribed and signed.

Operative Reports
Operative Reports must be dictated within 24 hours of surgery. After dictation is transcribed, Operative Reports need to be signed in the electronic dictation system by the performing surgeon. Electronic signatures are required within 30 days of the date of service. Physicians electing to use a system other than EOSC's electronic dictation system must provide copies of their Operative Notes to EOSC within 30 days of the date of surgery.

Signed Operative Reports cannot be removed or deleted from the medical record or electronic dictation system. Modifications to Operative Reports must be dictated as an addendum to the original document. Electronic signatures are required within 30 days of the date of service.

Nursing Documentation
All clinical documentation entered into the medical record should be done so during the patient visit. A random sample of nursing charts is reviewed quarterly for deficiencies. Deficiencies will be returned to nursing staff and must be resolved within 30 days. Quarterly deficiency rates are monitored by medical the Patient Care Committee who may recommend that daily audits or other procedures be implemented to decrease deficiencies for specific clinical departments.

Complete Medical Record
Medical records should be 100% complete within 30 days of surgery, which includes chart review. Medical records not complete within 30 days will be considered delinquent.

Delinquent Medical Records
All medical records not completed within 30 days are considered delinquent. A courtesy call, fax or e-mail will be made to performing physicians with delinquent records. A certified letter will also be sent to the performing physician for any delinquent medical record over 60 days from the date of service stating that no additional cases can be scheduled or performed until the record is completed. After 90 days, the physician will receive a letter from the Clinical Review Committee stating that the record must be completed within 15 days or the delinquency will affect recredentialing and requests for peer reviews from outside institutions.

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AUTHORITY AND RESPONSIBILITY

The Manager of Operations, in conjunction with the Medical Record Coordinator, is responsible for enforcing this policy.

EVALUATION AND IMPROVEMENT

The evaluation and effectiveness of this policy is conducted by the Manager of Operations and reported to the PCC, CRC and Board of Managers as appropriate. Included in the evaluation are recommendations for changes based on trends, incidents and regulatory standards. The CRC or Board of Managers may also provide direction on additional measures they wish the Manager of Operations to implement in order to ensure the objectives of the policy are met.

REFERENCES

CMS (Rev 56, Issued: 12/30/09, Effective/Implementation: 12/30/09)
§416.52 condition for coverage – Patient Admission, Assessment and Discharge