UNIVERSITY OF CALIFORNIA, DAVIS HEALTH SYSTEM

Guidelines for Effective Use of the EMR

Quality Clinical Documentation

Clinical Documentation Task Force
of the Medical Records Committee

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Executive Summary

UC Davis Health System's electronic medical record (EMR) is used by a wide variety of clinicians, medical and ancillary staff and patients. The EMR stretches across many different settings, including clinics, hospital, departments, research units, pharmacies, patient homes, outside providers and eventually other hospitals.

When used safely and effectively, the EMR has the potential to positively impact patient care, and enrich the educational experience of our housestaff and students. It also has the potential to impact the care of large groups of patients through disease surveillance, best practices and other decision support, population management of diseases, and research. When used carelessly however, the EMR can create confusion leading to inaccurate or misleading information and ultimately adversely affect patient care.

Purpose

To promote the safe use of the EMR and maximize the benefits the EMR offers, the UC Davis Health System supports the adoption of Best Practice Guidelines. Best Practice Guidelines serve to define a common ground and framework for using this tool. They are developed by clinicians and reflect a commitment to patient care, quality, and educational goals.

All members of the medical staff are required to be compliant with these guidelines as well as all other established policies and procedures.

Summary of Guidelines for Quality Clinical Documentation

1. Patient Centered
2. Timely
3. Appropriately Concise and Relevant
4. Accurate
5. Compliant
6. Appropriately Reviewed by Supervisor

1. **Patient Centered**
   Documentation must be patient-centered, reflecting the patient's current condition and trajectory of illness.

   Reason: When reviewed collectively, individual notes, should tell the patient's story and each individual note should clearly indicate for anyone retrospectively reviewing the medical record the updated author's assessment and the resulting treatment plan.

   The goal of the EMR-generated note, is the same as a paper note which is to reflect the events leading up to a clinic visit, admission (History and Physical) or of the last 24 hours (SOAP note/progress note), and to analyze data and show the thought process behind medical decision making for the day.

   A patient centered note includes:

   a. <u>Author review of content</u>
      Verify that all content accurately reflects the patient's current situation and trajectory of illness. When information is automatically transferred or values are defaulted, the author is responsible for reviewing all content, editing what is necessary to keep the information current, and ensuring relevance to the patient for the day it was authored.

   b. <u>Reflection of Individual Thinking</u>
      The note must reflect the thought process of the author. When it is necessary to share thoughts or information originating from another service, it is the author's responsibility to attribute where the information came from. Knowing where and from whom information is coming or identifying the source of information assists readers in establishing the correct perspective.

   For additional information and examples, see Appendix A

2. **Timely**
   Documentation must be up to date and project the most current picture of the patient's status. Notes must be entered in a time frame appropriate to the status of the patient and in the venue for which they are seen.

   Reason: Timely notes keep certain sections of the medical record up to date and accurate (e.g., problem list, allergies, medical decision making, etc.). Timeliness of information is essential for other care providers in the management of the patient.

   A timely note demonstrates:

   a. Reconciled problem list on transfer or handoff
   b. Assessment and Plan reflecting the current status

   For additional information and examples, see Appendix A.

3. **Appropriately Concise and Medically Relevant**

   Documentation must be appropriately concise to assist other members of the patient's care team in their search for relevant information. Every provider should strive for producing a chart for readers to follow chronologically a patient's trajectory of illness and current status.

   Reason: Physician notes are routinely the primary communication method between providers. Therefore, every note must be written with the perspective of, "What does someone need to know in order to care for the patient?" Notes must provide enough information for someone to quickly get up to date on the patient's current condition and plan of care, without excess information that would make reading it onerous.

   Appropriately Concise and Relevant Notes include:

   a. Information that is timely, pertinent, or not easily found in other sections of the medical record.
   b. References to where information can be found are acceptable.
   c. Notes that demonstrate the author's synthesis of data and, when relevant, clearly identifies new elements of the patient's condition or key parts of the note that reflect the patient's condition.
   d. Relevant information. Avoid copying forward information especially that which is no longer relevant to the patient's current condition.

   For additional information and examples, see Appendix A

4. **Accurate**

   The author is responsible for all documentation that is signed or cosigned, whether the content is original, copied, pasted, imported, or reused.

   Reason: Because electronic documentation may import data, (e.g., vital signs, problem list, care team members, etc.), authors must review all data and validate accuracy and appropriateness for the note.

   For additional information and examples, see Appendix A

5. **Compliant :**

   Documentation must be in compliance with all existing department/service, hospital regulatory, legal, and billing requirements.

   For additional information and examples, see Appendix B

6. **Appropriately Reviewed by Supervisor**
   Trainee notes must be appropriately reviewed in accordance with department/service policy and level of supervision required.

   If it is necessary for faculty to add information to a note they are cosigning or addending, they should place their linking language statements at the top of the note and clearly communicate if there is new or pertinent information.

   For additional information and examples, see Appendix A

Appendix A: Note Properties

Note Elements

	Do	Do Not
Patient Summary/ID	• Provide a succinct statement that can be used to quickly identify the patient or indicate why the patient is being seen.	• Do not write a lengthy summary that is repeated in the Assessment and Plan.
Interval History	• Include key patient events since the time the last note was entered by the service/physician.	• Do not repeat/copy interval history into subsequent notes that is no longer relevant to the patient's situation.
Subjective	• Limit the subjective to brief statements.	• Do not copy the Assessment and Plan.
Objective	• Note relevant physical exam findings and how they are different from past exams. • Bring attention to significant changes by using bold print or underlining.	• Do not copy physical exam findings from another provider's note. • Do not copy forward the physical exam findings without noting differences or updating the findings.
Labs	• Provide critical analysis of trends. • Summarize key findings.	• Do not clutter the note with extraneous lab information. • Do not use lab smart links as a substitute for reviewing lab data in Results Review.
Assessment	• Provide a conclusion about the patient's diagnosis, status and differential diagnosis by providing analysis of the subjective and objective information. • Include critical analysis of data to support conclusions. • Update the assessment as appropriate.	• Do not solely list subjective and objective information. • Do not copy assessments from another service.
Problem List	• Move resoled problems to "medical history" if, in the clinician's judgment it might be relevant to the patient's care in the future.	• Do not leave resolved problems on the problem list.
Plan	• Keep the patient's plan up to date and relevant to the current status. • Always include actual date to note events and/or plans.	• Do not copy forward a plan that is not updated. • Do not use vague references to time such as yesterday, tomorrow or next week.

Note Process

	Do	Do Not
File Time	• Notes should be filed as soon as possible following your department's service policy. • May use separate notes or addendums for events that happen after rounds or while on call.	• Do not delay the filing of notes.
Addending	• Place new or important information at the top of the note. • Place linking language above if noting new or important information.	• Do not delete the original note from the addendum.
Sharing	• Share notes only if the workflow has been approved by the department.	• Do not delete shared notes unless you are the author.

EMR Tools

	Do	Do Not
Note Templates	• Use preapproved department or general note templates when appropriate.	• Do not delete or edit sections from department and/or general templates.
SmartLinks	• Use Smart Links selectively when the data is needed to support analysis or conclusions. • Use SmartLinks selectively to import data that is pertinent and adds substance.	• Do not use Smart Links if they add to the length of the note without increasing content/analysis. • Do not use Smart Links if the data is easily found somewhere else in the chart. Document that the data was reviewed, and it is permissible to direct readers to where the data is stored (e.g. Results Review).
Copy/Paste	• Use copy paste cautiously. • When using copy paste, ensure that information imported through Smartlinks is refreshed.	• Do not copy the physical exam from anyone else. • Do not copy an assessment and plan from other services. • Do not copy medical student notes. • Do not copy information without validating that it is accurate (i.e., vital signs, problem list, etc.)

Appendix B: Required Compliance Elements

The required elements listed below are incorporated into the general and service specific templates to account for Federal, State, Joint Commission and billing requirements as well as UC Davis Rules and Regulations of the Medical Staff.

Providers may save templates as personal dot phrases and modify them as needed. However, providers are responsible for ensuring that the following required elements are present in all of their notes.

History & Physical

Required Elements:

- DOS
- Chief Complaint
- History of Present Illness
- Past Medical History
- Family History
- Social History
- Review of Systems
- Physical Examination
- Assessment
- Treatment Plan

Consultation Notes

Required Elements

- Type of Consult
- Name of the attending physician requesting the consult
- Reason for Consult
- Chief Complaint
- Pertinent Medical History & Physical Examination
- Assessment and Recommendations

Consultation Follow-Up Note

Required Elements:

- Assessment
- Recommendation(s)

Daily Progress Note

Required Elements:

- Current or working diagnosis
- Any change in condition (complications, hospital acquired infections, unfavorable reactions to drugs or anesthesia, results of treatment)
- Physical Examination
- Assessment

Attending Admit Note

Required Elements:

- Link to resident's H&P
- Historical Findings
- Examination Findings
- Attending Conclusion
- Attending Recommendation

H&P Update (use if there is a complete H&P done within the last 30 days)

The H&P update is to be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

The documentation must indicate:

- Airway assessment
- The completed H&P has been reviewed, **and**
- The patient has been examined, **and**
- Either no relevant changes have occurred, OR details the changes in the patient's condition since the prior H&P.

Immediate Pre-Sedation Assessment

The Immediate Pre-Sedation Assessment is to be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

Proceduralists must use the hospital approved template as it includes:

- Airway assessment
- The completed H&P has been reviewed, **and**
- The patient has been examined, **and**
- Either no relevant changes have occurred, **OR** details the changes in the patient's condition since the prior H&P.

Pre Anesthesia Note (Required for all surgery and conscience sedation procedures)

Required Elements:

- Pre-operative diagnosis
- Assessment of upper airway
- Anesthetic risk
- Anesthesia, drug and allergy history
- Any potential anesthesia problems identified
- Informed consent discussion
- Patient's condition immediately prior to induction

Post Anesthesia Follow Up Report

Required Elements:

- Vital Signs and level of consciousness
- The presence or absence of complications related to anesthesia
- Any follow-up care and/or observations
- Discharging physician and/or compliance with approved discharge criteria

Immediate Post Operative/Bedside Procedure Note

Required Elements:

- Pre and post operative diagnosis
- Name of procedure
- Name of surgeon and assistants
- Type of anesthesia administered
- Description of the procedure, surgical technique
- Findings
- Specimens removed
- Estimated blood loss
- Complications and patient outcome
- Report signed by surgeon

Procedure Notes

Required Elements

- Date of Service/Date of Procedure
- Preoperative Diagnosis
- Postoperative Diagnosis
- Name of Procedure(s)
- Type of Anesthesia
- Findings

- Description of Procedure/Surgical Technique in Detail
- Complications
- Estimated Blood Loss
- Specimens
- Outcome
- Name of Surgeons and Assistants
- *Optional Elements: fluids in, urine output, drains, sponges, needles and instrument counts*

Discharge or Final Progress Note

Required Elements:

- Final diagnosis
- Significant findings
- Events of the hospitalization
- Condition on discharge
- Discharge instructions
- Required follow-up care

Discharge Summary (*May continue to be dictated)*

Required Elements:

- Admission and Discharge Data
- Discharge Diagnosis
- Reason for Admission and Summary of Present Illness
- Significant Findings of Physical Exam, Lab and X-Ray
- Consultations
- Procedures Performed/Treatment Rendered
- Hospital Course
- Complications
- Disposition of patient: Including Condition at Discharge
- Follow-Up Care
- Instructions to Patient/Family: Including Diet, Activity, Medications

Internal Transfer Note (Level of Service Change, But Treatment Team the Same)

Required Elements:

- Current diagnosis at transfer
- Any change in condition (complications, hospital acquired infections, unfavorable reactions to drugs or anesthesia, results of treatment)

Death Note (Death Summary must be dictated)

Required Elements:

- Date and time of death
- Notification of the next of kin

Signature Block Requirements

The Centers for Medicare and Medicaid Services (CMS) requires signature blocks to contain the following: date/time stamps and a printed statement e.g. "electronically signed by" followed by the provider's name and professional designation. UCDMC also requires training level, as applicable.

Acceptable electronic signature:

> **Electronically signed by:**
> **John Doe, MD**
> **Intern**
>
> **(The EMR automatically date/time stamps the note.)**

Appendix C: Related Policies

UCDHS P&P 2306 - Legal Medical Record Content/Core Elements
UCDHS P&P 1924 - Evaluation and Management Consultation Guidelines
UCDHS P&P 2713 - Clinical Consultation Policy for Patients

CMS Federal Condition of participation, Sec. 482.24: Medical record services
CMS Federal Condition of participation, Sec. 482.51: Surgical services
CMS Federal Condition of participation, Sec. 482.52: Anesthesia services

California Administrative Code, Title 22, Sec 70717, Sec 70223, Sec 70233, Sec 70749

Joint Commission Patient of Care Standard - PC.01.02.03, EP 5,6; PC.03.01.03, EP 1
Joint Commission Record of Care Standard - RC.02.01.01, EP 2; RC.02.01.03, EP 7,8; RC.02.04.01, EP 3

Rules & Regulations of the Medical Staff - University of California, Davis Medical Center, Sec I. I. 1-2., M.
Sec III. C., F.
Sec IV. A.
Sec IX. G., H., I., J