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| **Title:** | QUANTITATIVE ANALYSIS OF CLINICAL RECORDS | | **N° : ARC.3.30.10** |
| **Section :** | 3.Clinical Record Management | **Effective date :** | **2017-04-03** |
| **Issuing authority:** | Assistant Director Health Records | **Date of last revision :** | |
| **Approver :** | Vice-President, Performance, Quality and Corporate Services<br>Gisèle Beaulieu | **Approved on:** | 2017-03-03 |
| **Facility(ies) / Program(s) :** | | | |

## PURPOSE

To ensure that the medical content of clinical records, with respect to physicians' documents and notes, is complete and accurate, meets the requirements of the *Hospital Act*, and complies with established standards.

## POLICY

1. The clinical record, with respect to documents and information documented by the physician, must be verified within 10 days of the patient's discharge.

2. The person responsible for conducting the analysis ensures that the following elements are complete, signed, and dated for each inpatient, day surgery and outpatient clinical record.

   2.1 Documents in the record must contain at least the four following identifiers about the patient on both sides of the document:
   - record number;
   - name;
   - date of birth;
   - Medicare number.

   2.2 History and physical examination

   2.2.1 A complete history and physical examination report must be written/ dictated within 48 hours of a patient's admission.

   2.2.2 For a readmission that takes place within 30 days of the patient's discharge, the history and physical examination report can be brief, or a reference to the history and physical examination report from the previous hospital stay can be accepted.

2.2.3 A reference to a document describing the complete history and physical examination is accepted if it is dated within the previous 30 days (e.g. Emergency registration form and consultation form).

2.2.4 For stays ≤ 24 hours and day surgery under local anesthesia, a brief description on the outpatient registration form is accepted.

2.2.5 For surgery, the history and physical examination report must be in the record when the patient arrives at the Surgical Suite.

2.2.6 The history and physical examination report (signed and dated) is accepted if dated within 30 days of the procedure. If more than 30 days have passed since the report was written/dictated, the document must be signed and dated again to validate the information.

2.2.7 The history of the illness is not necessary for obstetrical cases, newborns, and oncology follow-up.

2.2.8 For newborns, a complete physical examination report at birth and on discharge must be written/ dictated, signed, and dated by the attending physician.

## 2.3 Outpatient/Emergency registration form

2.3.1 The diagnosis must be written and signed by the Emergency physician.

## 2.4 Progress notes

2.4.1 A progress note must be written at least once a week.

2.4.2 A postoperative note must be placed in the record.

2.4.3 A pronouncement of death note must be written by the physician or nurse/supervisor who ascertains the death.

2.4.4 A transfer note must be written when the patient is transferred to another physician. The transfer must be accepted by the receiving physician.

2.4.5 All progress notes must be dated and signed by the physician.

## 2.5 Labour and delivery

2.5.1 All sections of the “Pregnancy, Labour and Delivery/Obstetrics” form used during labour and delivery must be signed and dated by the delivering physician.

2.5.2 The original must be kept in the mother’s record and a copy placed in the newborn’s record.

## 2.6 Consultation

2.6.1 The reason for the request must be documented, signed, and dated by the requesting physician.

2.6.2 A report must be written/ dictated, signed, and dated by the consulting physician.

## 2.7 Consent

2.7.1 The form must include all mandatory signatures.

## 2.8 Anesthesia and Recovery Room report

2.8.1 The documentation forms must be signed and dated.

## 2.9 Operative protocol/Procedure

2.9.1 The pre-printed forms (for gastroscopy, colonoscopy, cystoscopy, and dental extraction) are accepted when signed and dated.

2.9.2 All reports about procedures performed in the Surgical Suite must be dictated within 24 hours of the procedure and signed and dated when transcribed.

2.9.3 For minor procedures performed in the patient's room or an outpatient clinic, a progress note containing a description of the procedure is accepted.

2.9.4 A medical imaging report is accepted when the procedure is performed by a radiologist.

## 2.10 Treatments and orders

2.10.1 Admission and discharge orders must be dated and signed by the attending physician (See Orders GEN.3.40.05 and Verbal and Telephone Orders NSG.3.20.70). Those written by students must be co-signed by attending physician (See 5.1).

## 2.11 Discharge summary or face sheet

2.11.1 The "Summary Sheet", (RC-82B) form must be completed, signed and dated by the attending physician, regardless of the length of the hospital stay.

2.11.2 The "Discharge summary" must include the following:

- dates of admission and discharge;
- final diagnosis:
- pre- and post-admission comorbidities;
- procedures performed;
- relevant points in the history and physical examination or mental examination, depending on the situation;
- relevant results of investigations conducted during the hospital stay;

- conclusion of the consultants, if applicable;
- progress in hospital;
- recommendations on discharge.

3. If one of the elements for a record to be considered complete is lacking (without, however, being limited to the elements listed under item 2), the record is returned to the physician in question for him or her to complete it.

4. When a physician is no longer practising within Vitalité Health Network and has incomplete records:

   4.1 Health Records, in collaboration with Medical Services, do their best to have the records completed before the physician leaves. They also do their best to contact a physician who has already left to have him or her complete the records.

   4.2 If this fails, a follow-up with the patient is done and the record is completed by the head of the medical department in question or a member designated by the department head.

   4.3 An explanatory note is placed on the record using the appropriate form "Physician Departure"(RC-83B), signed by the head of the medical department in question or a member designated by the department head.

5. Students and residents

   5.1 All documents, reports or orders written by medical students who have not completed their studies (medical trainees, external students and medical students) must be co-signed by the physician supervising the student.

   5.2 Documents, reports or orders written by residents (postdoctoral trainees) do not need to be co-signed. If in doubt, refer to the College of Physicians and Surgeons of New Brunswick to check the level of education of the trainee.

## PROCEDURE

1. Incomplete records are made available to the physicians so they can complete them.

2. As soon as a physician completes his or her records, he or she places them in the designated location. The Health Records Department then conducts verification and changes the status of each record in the Meditech system.

3. If records are still incomplete after 20 days of the patient's discharge, a "Notice- Incomplete Records" (RA-114B) is sent to the physician.

## ADDITIONAL RELEVANT INFORMATION

1. The last physician to whom a patient is transferred becomes the physician responsible, except if an agreement is concluded between the medical departments.

2. Only approved abbreviations may be used in clinical records. See policy GEN.6.20.45 “Abbreviations Permitted” and policy GEN.6.20.46 “Abbreviations, Symbols, and Dose Designations Not Permitted.”

3. A consent is required for all procedures, examinations, treatments and surgical procedures according to Section 20 (1) (g) of Regulation 92-84 under the *Hospital Act* and according to the facility’s or Network’s policies.

4. A physician has 30 days following the date of the patient’s discharge to complete the record. See policy ADM.6.10.10 Incomplete Records.

5. When it becomes clear that an error has been made, the person responsible for the analysis is authorized to make date corrections in the record based on the method set out in the book Canadian Health Information.

## REFERENCES

1. *Loi hospitalière H-6.1*. et Règlement 92-84, paragraphe 20(1).

2. Règlements administratifs du Réseau de santé Vitalité; octobre 2013; C.17.0.2 et Règles du personnel médical du Réseau de santé Vitalité.
3. Règles du Conseil des médecins et dentistes du N.-B.
4. Énoncés de principe de l’Association canadienne interprofessionnelle du dossier de santé.
5. Canadian Health Information, Third Edition, Lorne E. Rozovsky et Noela J. Inopns.

## DISTRIBUTION

AMD

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| **Supersedes:** | **Zone 1 :** 16.50.10 | **Zone 5 :** SUP-HR-5-20 |
| | **Zone 4 :** ARC-V-A-35 | **Zone 6 :** |