

Documentation – Best Practices

VA Palo Alto HealthCare System (VAPAHCS)

New Resident Orientation

Presented by Health Information Management Section (HIMS)

Please be sure to...

1. Read policy on Medical Record Documentation- [HCSM 11MR-11-08](#).
2. Pay attention to your delinquent note time frames.

Most Importantly:

Admission H&P	24 hours of admission
Discharge Summary	24 hours of discharge
Outpatient Progress Notes	Expected within 7 days of visit
Operative Procedure Note	Immediately post surgery

3. Complete AND Sign your notes. Notes can be entered through Computerized Patient Record System (CPRS) or dictated into dictation system. Ext 60515 Off site: 800-230-7655.
4. When entering notes in CPRS be specific of the date and time. Select appropriate date and time that reflects when you actually saw the patient.
5. Link your notes to **SCHEDULED** visits. This is the first step to documenting the care you give. This can be done in CPRS by selecting “New Note” and scrolling through “Clinic Appointments” tab or “Hospital Admissions” tab to find the correlating visit “awaiting” a note. If no appointment or hospital admission was created prior, then it is OK to select “New Visit” and proceed through prompts for necessary information.
6. Adding an addendum to existing notes is a tool to use if you have completed and signed your note and realize you need to add more information specific to the visit. Highlight note, go to “**Action**” in the tool bar across the top of screen and select “**make addendum.**”
7. Discharge Summaries **must** be created under “D/C Summary” tab in CPRS. Select **<DISCHARGE SUMMARY>** and you will be prompted to enter more information.
8. Document Resident Supervision according to medical setting and situation. The four approved documentation types are:
 - Attending progress note or other entry into the medical record
 - Attending addendum to the resident note
 - Countersignature by attending
 - Resident documentation of attending supervision
9. *Standard elements* you should always include in your documentation are: **chief complaint, history, physical, assessment, and plan**. Be specific!

Key points to remember

1. Prompt completion of records is mandatory for continuity of care and VA funding.
2. Don't abandon erroneously entered notes. Send a message to [g.document mail group](#) through VISTA - GUI Mail. Signed notes can be deleted and corrections made on: date/time, note titles, linkage, and co-signers.
3. All notes must be completed *prior* to rotating off service.

Please contact Health Information Management Section with any questions:
T. Wes Maynard ext: 64309 - Chief, HIMS
Patricia Brown ext: 66071 - Medical Records Administrator (Coding Educator/Vera Coordinator)
Ken Striebel ext: 65599 - Medical Records Technician
Ann T. Struck ext: 64648 - Support Service Specialist

Please note: Discharge summaries MUST be entered within 24 hours post discharge. In addition, the VAPAHCS policy differs from that of Stanford. A patient transferred, or a patient admitted under 24 hours to a ward, or a patient who expires ALL require completed discharge summaries.

This is a friendly reminder about the VA Palo Alto (VAPAHCS) policy re: medical record documentation.

Please read attached memorandum below as a refresher.

Please contact me if you have any question.

Kindly,

VETERANS AFFAIRS PALO ALTO HEALTHCARE SYSTEM

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HEALTH CARE SYSTEM MEMORANDUM NO: 11MR-07-08

SUBJECT: MEDICAL RECORD DOCUMENTATION

3. **POLICY:** Veterans Affairs Palo Alto Health Care System (VAPAHCS) health care providers shall keep thorough medical records, which document all significant information to ensure patients/clients receive proper care and the facility has the optimal opportunity to recover medical care cost.

(10) Discharge Summary:

- (a) A dictated or electronically entered discharge summary is required for all discharges/deaths, regardless of the length of time the patient spends in the inpatient setting.
Dictation and/or electronic data entry is required within 24 hours after discharge or death. When the house staff dictates or enters the discharge summary into CPRS, the supervising medical staff member (attending) at the time of discharge or death is responsible for electronically co-signing the summary. Additionally, the housestaff/resident dictating the discharge summary will also dictate the name of the supervising/attending physician to co-sign. All summaries must be signed-co-signed within 7 days after the discharge or death. The responsible physician will be defined as the member of the medical staff having primary care responsibility for the patient.

Health Information Management Section (11MR)

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MEDICAL STUDENT DOCUMENTATION
2011- VAPAHCS

The Office of Academic Affiliations will be drafting updated guidelines for medical student (and associated health trainee) supervision in the future as part of a planned transition from the “Manuals” to Handbooks. *In the interim, please keep the following principles in mind.*

- § **Medical students are students and are neither licensed physicians nor resident physician trainees.**
- § **Medical student notes are not acceptable in lieu of resident notes.**
- § **If viewable, a medical student notes should be clearly labeled as “Student Notes.”**
- § **Where medical students are involved....the attending staff physician or the resident must be physically present in the room during patient visits/exams.**
- § **It is not acceptable for a resident or the attending staff physician to simply cosign a medical student note. It is important for the resident or attending staff physician to write an independent note or an addendum that signifies an independent evaluation of the patient that comes to independent conclusion.... this note must include elements of the Physical Exam done by the resident or the attending staff physician.....**

.....Medicare has stated that we can count the PFSH (past family social history) and the ROS (review of systems) when documented by a medical student, but nothing else. The licensed provider (resident or attending staff physician) must perform and state what the physical exam elements are in order to bill.
- § **The supervising / attending staff physician is ultimately responsible for the evaluation and management of the patient and for the supervision of all trainees assigned to work with him/her. While some of the day-to-day supervision of medical students may be delegated to residents, the attending staff physician retains medical-legal responsibility for the patient’s care.**
- § **When medical students type a progress note but leave it unsigned, the attending staff physician may edit and sign the note FOR the medical student; however, it’s important that the attending staff physician include a statement in the note such as: “I have independently examined the patient with the following findings...list or summarize the actual findings from the examination, etc.”**