

Title: HIMS: Medical Record Documentation	
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Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Behavioral Health Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner Ocotillo Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner—University Medical Center Phoenix Banner—University Medical Center South Banner—University Medical Center Tucson East Morgan County Hospital McKee Medical Center North Colorado Medical Center Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional MedCenter Torrington Community Hospital Washakie Medical Center	Banner Corporate Ambulatory Services Banner Health Clinics Banner Imaging Services Banner MD Anderson Cancer Center Banner Surgery Centers Banner Urgent Care Centers Occupational Health/Employee Services Rural Health Clinics Banner Home Care and Hospice Insurance Banner Health Network Banner Plan Administration University Physicians Health Plans Banner Pharmacy Services Post-Acute Care Services Research

I. Purpose/Population:

- A. To provide general guidance to support accurate and complete medical record documentation in all Banner system clinical applications defined on the Banner Health EHR Map.
- B. This policy applies to All Employees.

II. Definitions:

- A. BITMAP- a digital image composed of matrix dots. When viewed together these dots can represent a picture or logo.
- B. EHR – Electronic Health Record
- C. Cerner – A clinical data repository that maintains electronic documentation and treatment outcomes
- D. CIMT – Clinical Information Management Team
- E. Cloned/Copied/Paste Documentation – For the purpose of this policy, the term copy means any one of the following synonyms; copy and paste, cloning, copy forward, re-use, and carry forward, copy forward and save note as a template. Each entry in the medical record is exactly like or similar to previous entries. Copying is the process of carrying forward text in the record and pasting in a new destination. Additionally, cloning also occurs when documentation from one patient is the same as another, i.e., problem, symptoms, treatment is identical.
- F. Dragon – Speech recognition software turning dictation into text.
- G. Dynamic Documentation – Cerner documentation solution that pulls data from the patient medical record (for example: allergies, chief complaint, diagnosis, medications) and allows providers to create free text entries, alongside medical data, for flexible and efficient clinical documentation. Portions of the patient medical record are dynamically populated with results and data from the Cerner Millennium patient data stream.
- H. HIMS – Health Information Management Services
- I. Sensitive Note – Notes that are filed separately in the medical record and are not released based on a Release of Information request.
- J. SCAN Note: Suspected Child Abuse and Neglect Note. This note type is considered a Sensitive Note.
- K. Shadow Records: Records that are maintained outside of the Electronic Health Record.
- L. Tagging – is the process of highlighting existing pieces of documentation and lab results in Cerner to be included in clinical documentation.

III. Policy:

- A. The provider/practitioner who treats the patient shall have the ultimate responsibility for documenting and authenticating the care rendered. The documentation shall be in accordance with:
 - 1. Generally accepted professional standards of documentation that includes original, copied, pasted or imported. The provider is responsible for the accuracy of all documentation entered including imported, copied and pasted information.
 - 2. Specifically, mandated regulatory, legal and/or accrediting standards.
 - 3. Documentation guidelines developed in concert with this policy statement and approved by the medical staff.
 - 4. Providers documenting in the EHR must avoid indiscriminately copying and pasting documentation from other parts of the applicable patient's records. Documentation in the medical record must be specific to each patient encounter. Cloned/Copied/Pasted documentation may be considered a misrepresentation of the patient condition and can lead to potential patient safety concerns and financial sanctions to the facility.

- a. Copy forward from one date to another for the same provider is limited to those portions of the medical record that:
 - i. Auto-refresh daily (e.g., smart templates)
 - ii. Defined fields within the medical record that would not be expected to change day to day (e.g., Family, Social, and Past Medical histories)
 - iii. Coded entries (e.g., ICD-10 diagnosis)
5. Potential issues of copy/paste functionality being used inappropriately will be referred to the facility HIMS Director and Medical Staff Services Leader.
 - a. Copying or cloning documentation may be acceptable when it is:
 - i. Based on verifiable sources, i.e., demographic data such as name, DOB.
 - ii. If the provider uses information from a prior note, he/she must reference the date of the previous note or original source. This is currently supported in Cerner Dynamic Documentation by using the tagging functionality. If the tagging functionality in Cerner is not utilized, the documentation is a violation of copy/paste guidelines as noted above.
 - b. Copying or pasting a BITMAP or office logo into the EHR is not permitted.
 - c. Providers are responsible for clearly identifying who performed each service documented within the note. When copying patient data into the medical record that the provider did not personally take or test, the provider must attribute the information to the person who did unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider (as it occurs automatically when using the tagging functionality in Cerner Dynamic Documentation).
 - d. If the provider references a form within the record, he/she must reference the form with enough detail to uniquely identify the source. Example: "for review of systems, see form dated 6/1/13."
 - e. If the provider copies a template, the provider shall review the template in its entirety and make modifications appropriate for the patient. If a provider copies a prior entry that the provider authored, the provider shall review the entry in its entirety and make appropriate modifications based upon the patient's current status and condition.
- B. Shadow records are not permitted, however printing of records to prepare for the day's schedule is permitted for patient care. Printed documents should be handled in accordance with Banner Health policies (HIMS Scanning of Documents (Decentralized) to be Included in the EMR and Records Retention and Destruction).
- C. Prior to transmission of the Summary of Care document for those patients transferred to the next level of care, a designated provider may review and reconcile the documented problem list, medications, and allergies in the Electronic Health Record, based off the documentation entered by the treating providers, to ensure regulatory compliance and support continuity of care. The provider will document a note indicating that this review was completed.
- D. Other professional staff may document concise notes related to patient goals and response to treatment. The following personnel have the right to document in the health record according to and consistent with their scope of practice and authority:
 1. Medical Staff
 2. Nursing Staff
 3. Allied Health Staff
 4. Dietitians
 5. Physical Therapists
 6. Occupational Therapists
 7. Speech Pathologists
 8. Recreational Therapist
 9. Addiction Therapists
 10. Mental Health Counselor

11. External UM Reviewers
12. Affiliated Medical/PA/Nursing or Other Students
13. Pharmacists
14. Social Services
15. Case Workers
16. Case Management Staff
17. Respiratory Therapists
18. Chaplains
19. Physicists
20. Affiliate Staff
21. Residents/Fellows
22. Scribes
23. Departmental Technicians with specific job requirements for documentation responsibilities

* No other persons shall be authorized to enter, change, sign or authenticate material in the health record. (See System Policy: Administrative Closure of Incomplete Medical Records, #6036)

- E. All entries in the health record, both paper and electronic format, must be dated, timed and properly authenticated at the conclusion of each entry which shall consist of the provider's name and professional title indicating the professional credential. When only initials are used, the signature is noted on the document.
- F. The use of electronic signatures is an approved method of authentication. (Policy: HIMS: Authentication of Medical Record).
- G. Entries made by the following providers may require counter-authentication as defined by the Medical Staff Rules and Regulations, all entries in the health record, both paper and electronic format, must be dated, timed and properly authenticated at the conclusion of each entry:
 1. Physician Assistants
 2. Advanced Practice Nurses
 3. Affiliated students such as medical students, physician assistant students, advanced practice nurse students, and similar students
 4. House Staff, Residents, and Fellows on formal rotations at non-teaching/training facilities
 5. House Staff, Residents, and Fellows at teaching/training facilities:
 - a. Requirements for counter-authentication will be established and monitored by specific training programs. The Health Information Management Services Department does not monitor counter-authentication for House Staff, Residents or Fellows and deficiencies do not result in temporary suspension imposed pursuant to Medical Staff rules. Appropriate action will be taken by the specific training program.
- H. Each clinical event must be documented as soon as possible after its occurrence. Times documented in the EHR are consistent with the time zone where the event occurred and was documented.
- I. Banner will accept physician pre-admit orders, prenatal information, and pre-operative surgical History & Physicals from a physician office for inclusion in patient's hospital record. All other reports (Operative Reports, Consultations, Discharge Summaries, and Progress Notes) will be completed utilizing Banner approved formats, exceptions may be made on review and approval from CIMT on a case by case basis. (See Policy: Medical Record Forms and External Documents Policy)
- J. Entries must be legible and completed in permanent ink when handwritten. No highlighters may be used within the documentation, as it may become illegible during the scanning process.

- K. All entries must be made utilizing BH electronic systems or BH approved forms in the absence of an electronic system except as permitted by Medical Record Forms and External Documents Policy.
- L. When the form is completed in any language other than English the English version must be scanned for reference and interpretation.
- M. Pages that contain numeration must be scanned in total. For example, Page 1 of 2 must also contain Page 2 of 2 when scanned, even if the page is blank or does not contain handwritten documentation.
- N. Only approved abbreviations and symbols should be used when documenting in the health record. (See Policy: Medical Record Abbreviations and Symbols) When using Dragon software, dictated medical abbreviations will be changed to the detailed description.
- O. Patient identification is on all documents in the medical record.
- P. Corrections:
 - 1. To a handwritten documentation should be made in the following manner:
 - a. A single line drawn through the inaccurate information, ensuring the original entry is still legible.
 - b. The correct information entered and authenticated with the current date and time.
 - 2. To electronic documentation:
 - a. Corrections must be made in accordance with related policies and procedures. (See Policies: In-Error Documentation in Cerner and Clinical Documentation in the Electronic Medical Record (EMR))
 - i. By electronically entering an amendment in the applicable EHR; or
 - ii. By handwriting an amendment to a paper copy to be scanned into the EHR.
 - b. If the image is stored electronically, the entire document (not only the corrected pages) must be rescanned into the EHR after the correction has been made.
- Q. The nursing process is documented for each patient from admission through discharge. (See Policy: Clinical Documentation in the Electronic Medical Record (EMR),)
- R. Patient- handwritten documentation or paper-based documents will be scanned to the electronic medical record in a timely manner that is consistent with applicable procedures.
- S. Once a note is signed or authenticated as final, additional information may only be added as an addendum.
- T. Sensitive documentation: Sensitive documentation, such as documentation of suspected abuse, pediatric or adult, or psychotherapy notes, should be saved as "Sensitive Note" type, which will go to the "Sensitive" folder in the EHR. The provider will use the "Title" to specify the exact type of note being created (for example SCAN Medical Consult, or Suspected Abuse Note). The "Sensitive Note" type is available to view only to limited user positions in the EHR. These documents will not be visible in the Patient Portal and will not be released based on a "Release of Information" request from a parent/guardian or patient. These documents may be released to law enforcement agencies, Child Protection Agencies, Adult Protective Services, valid subpoenas, or other Providers caring for the patient that specifically request the sensitive documentation.

IV. Procedure/Interventions:

- A. N/A

V. Procedural Documentation:

- A. N/A

VI. Additional Information:

VII. References:

- A. CMS Medicare Part A brochure:
[http://medicare.fcso.com/Publications_A/2006/138374.pdf#search="cloneddocuments"](http://medicare.fcso.com/Publications_A/2006/138374.pdf#search=)

VIII. Other Related Policies/Procedures:

- A. Administrative Closure of Incomplete Medical Records
- B. Clinical Documentation in the Electronic Medical Record (EMR)
- C. Facility Medical Staff Rules and Regulations/Policies
- D. HIMS: Authentication of Medical Record
- E. HIMS: Data Integrity Medical Record Program
- F. HIMS Inclusion of Images in the EMR
- G. HIMS: Scanning of Documents (Decentralized) to be included in the EMR
- H. In-Error Documentation in Cerner
- I. Medical Record Abbreviations and Symbols
- J. Medical Record Forms and External Documents Policy
- K. Record Retention and Destruction
- L. Physician Practices/Clinics: Documentation for Coding Quality, Compliance, and Timeliness of Documentation Completion
- M. Scribes in the Emergency Department for Independent Physicians

IX. Keywords and Keyword Phrases:

- A. Addendum
- B. BITMAP
- C. Documentation
- D. EMR
- E. HIMS
- F. Medical Record
- G. Electronic Signature
- H. Signature Authority
- I. Copy
- J. Paste
- K. Clone
- L. Tagged Documentation
- M. Tagging
- N. Sensitive Note
- O. SCAN
- P. Shadow Record

X. Appendix:

- A. N/A