Documentation and completion of out-patient encounters in the electronic medical record

March 2010

Key Content Expert: Dr. David Sarne, Chair, EMR Documentation Committee

These systematically developed statements have been created to assist practitioners in documentation within the Electronic Medical Record. They are not to be construed as an inflexible set of correct procedures. Guidelines are based upon recommendations of multi-disciplinary committees. Variation from these guidelines does not, in itself, constitute improper care or improper professional judgment. Evaluation of these variations requires detailed analysis of the facts and circumstances surrounding the individual practitioner’s documentation.
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO DOCUMENTATION GUIDELINE
NO.: G-4.7 DATE: March 2010

SUBJECT: Documentation and Completion of Out-Patient Encounters in the Electronic Medical Record

OBJECTIVE

To provide guidelines on minimal requirements for documentation of out-patient encounters and on the completion of documentation of out-patient encounters within the Electronic Medical Record (EMR). The Electronic Medical Record is intended to produce an accurate and timely record of the status of the patient, medical decision making, and the outcomes of treatment. As documentation may be used by multiple individuals for clinical, educational, compliance, financial and legal purposes, information must be accurate and complete.

POSITION STATEMENTS

Documentation is required for all patient visits. This should include the reason the patient is there, what happened at the visit, and what should occur after the visit. In addition, notes need to be finalized in a reasonable time period after the encounter and after the initial documentation has been placed in the record.

PROCEDURE

I. DOCUMENTATION OF OUTPATIENT ENCOUNTER
   A. General Rules
      1. A note is required for each encounter
      2. Notes may be entered by
         a. Direct entry
         b. Power Note
         c. Dictated Note
         d. The use of an approved form which is scanned into the EMR
         e. Other approved documentation methods
      3. Separate (double) documentation in the encounter note is NOT required for information added into specific sections of the EMR (i.e. immunizations, allergies)

   B. Specific Documentation Requirements
      1. The following must always be documented:
         a. Reason for the patient’s visit
         b. Planned Follow-up (this could include no follow-up needed or termination of care)

      2. The following must be documented if they occurred at that visit
         a. Documentation of history obtained
         b. Documentation of physical examination performed
         c. Documentation of education provided
         d. Documentation of any changes in therapy
         e. Documentation of any ordered test or procedures
         f. Documentation of any ordered consultations
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO DOCUMENTATION GUIDELINE

3. For each encounter, a licensed provider’s documentation must be in the record within 2 business days (48 hours) of the encounter.

II. COMPLETION OF OUTPATIENT DOCUMENTATION

A. Completion of Preliminary Notes

1. Notes that are initially in preliminary status
   a. Directly entered notes that are saved but not signed
   b. Dictated notes after transcription

2. Preliminary notes should be finalized
   c. In three business days (72 hours) after the encounter
   d. Errors, omissions should be corrected
   e. Note must be signed

B. Completion of Forwarded Notes

1. Notes forwarded for signature
   a. Should be signed within 4 business days (96 hours) after the encounter
   b. An addendum should be included as appropriate
   c. The recipient can select “refuse” for a note sent incorrectly.

2. Notes forwarded for review
   d. If note should have been forwarded for signature, above guideline applies.
   e. If information is only to be reviewed, no signature is required.

Rescission

May 2007