Southern Health Santé Sud

Completion of Health Records Standards

<table>
<tr><th></th><th>Requirements/Content</th><th>Authentication</th></tr>
<tr><td>Facesheet:
• Inpatient- Completion of facesheet is required for only length of stays (LOS) less than 48 hours, unless there is a completed discharge summary

• Day Surgery- Completion of facesheet is not required, when there is a completed Operative Report</td><td>Use of abbreviations on the facesheet is strongly discouraged.

Primary Diagnosis, and where applicable:
• Associated conditions relevant to current admission
• Other conditions that increase the length of stay or alter the course of treatment
• Complications
• Operative procedures or other interventions
• Cancellation reason (if planned intervention is cancelled)
• Client's disposition at end of stay</td><td>Inpatient Facesheet must be completed as per required content listed, signed, and dated by the Attending Physician for only LOS less than 48 hours. Health Information Services will not flag as a deficiency if a discharge summary is completed.

Day surgery facesheet summary is no longer required, when there is a completed Operative Report.

Health Information Services will not flag a missing date related to a signature as a deficiency.

All facesheet summaries completed by a Medical Student (with "M" behind their signature) and Clinical Assistants must be counter signed by the attending physician. All summaries completed by a Resident (with R# behind their signature) do not need to be counter signed by the attending physician.</td></tr>
<tr><td>Facesheet:
• Emergency- non EDIS sites only
• Outpatient Visit</td><td>Use of abbreviations on the facesheet is strongly discouraged.

Primary Diagnosis, and where applicable:
• Interventions performed
• Client's disposition at end of visit</td><td>Must be completed with required content listed, signed and dated by the Attending Physician

Health Information Services will not flag a missing date related to a signature as a deficiency.

All facesheet summaries completed by a Medical Student (with "M" behind their signature) and Clinical Assistants must be counter signed by the attending physician. All summaries completed by a Resident (with R# behind their signature) do not need to be counter signed by the attending physician.

Exception: Emergency Department/Outpatient Visit Facesheets do not require a signature when the physician has not provided direct care, physician orders and/or treatment.
Examples include, but are not limited to:
-Physiotherapy;
-Occupational Therapy;
-Respiratory;
-Left before being seen;
- Transferred to another facility where a physician is on call</td></tr>
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		- Repeat visits with order in place, where treatment is provided by nursing staff only.
	Requirements/Content	**Authentication**
Discharge summary (includes transfers and/or deaths)	Required for: • All Inpatient Deaths regardless of Length of Stay (LOS) or Service/Program; • All Day Surgery Deaths regardless of Length of Stay (LOS) or Service/Program; • A discharge summary is recommended for all Inpatient stays regardless of LOS but is required for all Inpatient Discharges with Length of Stay (LOS) greater than **48 hours.** **EXCLUDES** discharges from Respite and Boarder mom/babe's care. Must include the following: • Author's name and position • Admission diagnosis • History of present illness • Distribution of copies required i.e. referring physician, family physician, etc. • Brief summary of the management of each of the medical problems during the admission, including investigations, treatments, complications and outcomes. • List of discharge diagnoses • Discharge medications and follow-up instructions	Signature by author optional (stamped Dictated Not Read is acceptable) for dictators not utilizing eSignature. When a discharge summary is transcribed and if eSignature is provisioned, a signature will be required. All summaries completed by a Medical Student (with "M" behind their signature) and Clinical Assistants must be counter signed by the attending physician. All summaries completed by a Resident (with R# behind their signature) do not need to be counter signed by the attending physician. Transfer/referral letters are acceptable as a form of discharge summary and will be filed in the discharge summary location in the record. An addendum is required if the discharge summary is dictated and the client does not leave the facility within 24 hours *Transcribed documents are strongly recommended to ensure legibility and access via electronic health information systems*.
Discharge summary – Obstetrical clients	A discharge summary is recommended for all Inpatient stays regardless of LOS but is required for: • Antepartum admissions with LOS greater than **48 hours** • Post partum admissions with LOS greater than **48 hours** • Delivered inpatients who meet the following criteria (regardless of LOS): -Delivery of premature infant <37 weeks -Delivery by instrumental intervention (forceps and vacuum) -Delivery by **unplanned** Cesarean Section -Malpresentation, vaginally delivered (Breech or face) -Post partum hemorrhage (blood loss >1000 cc's) -Delivery of a stillbirth **Exception:** Discharge summary is not required if the mom's LOS was increased due to the increase in LOS for the newborn or if admitted as a boarder mom.	
Discharge summary	A discharge summary is recommened for all Inpatient stays regardless of LOS but is	

-Newborns	<u>required</u> for: • Transfers to an Intermediate or Intensive Care Unit; regardless of LOS • LOS greater than **48 hours** **Exception:** Discharge summary is not required if the newborn's LOS was increased due to the increase in LOS for the mom or if admitted as a boarder baby.	
Operative Report	Must include the following: • Pre-operative diagnosis • Proposed operative procedure • Operative procedure performed • Description of procedure performed; • Findings at operation; • Condition of client during and at conclusion of operative procedure; • Post-operative diagnosis A separate Operative Report must be dictated for each visit to the Operating Room	Must be completed, signed by the Surgeon/Physician performing the operative procedure. *Transcribed documents are strongly recommended to ensure legibility and access via electronic health information systems.*
Consultations	Must be completed during the admission of the client	Health Information Services will **not** flag this as a deficiency post discharge if not completed. When a consultation is transcribed and if eSignature is provisioned, a signature will be required.
History & Physical	Must be completed upon/prior to admission of the client	Health Information Services will **not** flag this as a deficiency post discharge if not completed. When a history & physical is transcribed and if eSignature is provisioned, a signature will be required.

IMPORTANT POINTS TO CONSIDER:
Dictated documents using the Provincial Dictation and Transcription (PDAT) system for operative reports, discharge summaries,etc. is strongly recommended. Documents generated through PDAT interface into the hospital electronic patient record making them accessible to authorized health care professionals across acute care facilities provincially for the provision of quality health.
E-signature is also encouraged as this web-based application enables physicians to efficiently review and sign documents on any electronic device, rather than having to review and sign paper documents in Health Information Services or at the Unit Level.
Noting, when reports are not reviewed and signed in a timely manner via E-signature, a chart copy will not generate to be filed on the facility health record or be distributed (faxed) to requested recipents. Patient care decisions and physician billing may be delayed as a result. Health Information Services Leadership will monitor and may proxy sign any documents held in the PDAT system due to noncompliance, that have been awaiting review and signature for more than four months.