

VANDERBILT  UNIVERSITY
MEDICAL CENTER

Policy: Documentation Standards for Providers

Category Information Mgmt.
Approval Date March 2022
Effective Date March 2022
Supersedes October 2021

Applicable to

VUMC

Team Members Performing

All faculty & staff Faculty & staff providing direct patient care or contact MD House Staff APRN/PA RN LPN
 Other:

Responsible Committee

Clinical Operations Committee Pharmacy, Therapeutics, and Diagnostics Committee
 Clinical Practice Committee Health Record Executive Committee
 Quality Steering Committee Information Privacy and Security Executive Committee
 Infection Prevention Executive Committee Medical Center Safety Committee

Content Experts

Lead Author: Gaye Smith, Center for Health Information Management (CHIM)
CHIM Advisory Group

I. Purpose:

To define standards for clinical documentation to achieve a complete and accurate medical record that supports safe patient care, while supporting the business and legal purposes of Vanderbilt University Medical Center (VUMC).

The scope of this policy includes clinical documentation requirements associated with admissions for an inpatient level of care, same-day surgery encounters, outpatient encounters, and hospital stays classified as observation status for members of the VUMC medical staff and Professional Staff with Privileges. Additional documentation requirements are defined in separate policies and referenced at the end of this policy.

II. Policy:

VUMC requires that the responsible Provider accurately and concisely document the care, treatment, and services provided, including the information gathered by the Provider during each patient encounter, in a timely fashion. Providers attempt to complete all documentation at the conclusion of each encounter with the patient, and in no instance may documentation be completed later than the defined

time requirements set forth in this policy. Documentation not completed in accordance with established time requirements is considered delinquent. The medical record is not complete until all documents are finalized.

III. Definitions:

- A. See [Defined Terms Used in Information Management Policies \(SOP\)](#) for the following definitions used in this policy:
1. Attending;
 2. House Staff;
 3. Legal Medical Record;
 4. Professional Staff with Privileges; and
 5. Provider.
- B. Attestation of a clinical note (Attestation) – Signing of a clinical document by an Attending or consulting physician certifying that documentation created by a Supervisee, along with any edits and elaborations made by the Attending, is accurate and states the Attending’s presence and personal involvement in the care encounter. Attestations typically represent a billable document. VUMC permitted Attestations under this policy include:
1. Attestation of a resident or fellow evaluation and management service note by a teaching physician, with the Attending’s date of service performed;
 2. Attestation of a resident or fellow surgical, procedure, or anesthesia note;
 3. Attestation of a medical student evaluation and management note under the Medical Student Documentation in the Medical Record Policy.
 4. Attestation of a member of Professional Staff with Privileges note by a proctor physician when in training to perform additional procedures at VUMC.
- C. Change in clinical note – Reflects collectively the actions of amendments, corrections, retractions, or clarification to documentation.
- D. Finalized document – A document to which a final signature is affixed and/or an electronic document that has been saved as final. Where

specified, the final signature is required to be that of the Attending physician.

- E. Hospice Patient Class – Patients of VUMC who are transitioned to Hospice care after the patient or the patient’s legal representative has executed an Election of Hospice Benefit (EHB) form. This patient class should only be used for the treatment of the terminal conditions for which hospice care was elected.
- F. Signature on a clinical note (Co-Signature) – Signing of a document by an Attending physician signifying that he or she has reviewed the document that was created by a Supervisee, other VUMC member of medical staff, Professional Staff with Privileges, or clinical staff. The act of signing indicates that the Attending physician agrees with the document content. The Attending may or may not have been present at the time the evaluation, management, and care was provided. Unlike Attestation of a clinical note (see paragraph B above), a simple signature typically is intended to satisfy regulatory or educational program requirements and does not represent a billable document for the Attending physician.
- G. Supervisee – An individual involved in providing the care of the patient and who completes documentation in the course of his or her training, professional practice, or on behalf of the Attending. Examples include fellows, residents, and non-physician Providers. Fellows who are in an approved training program and are credentialed as faculty are subject to this policy consistent with their role at the time of the documentation (either as a Supervisee or as an Attending). Fellows who are in an unapproved training program and who are credentialed as faculty members are subject to this policy as an Attending unless the service was jointly performed with their supervising physician.

IV. Specific Information:

- A. Authentication of entries:
 - 1. Every documented entry, including patient-created documentation, in the LMR includes the date and time the documentation was created.
 - 2. Every documented entry is signed by the creator of the documentation.
 - 3. All clinical documentation reflects the date of service.
 - 4. Electronic signatures meet the requirements as defined in VUMC policy, [Electronic Signature: For Documentation in the Medical Record](#).

- B. Avoid repetitive charting. Refer to VUMC policy, [Carry Forward of Clinical Information in the Electronic Health Record](#).
- C. Handwritten documentation is discouraged.
- D. Specific and objective language is used in all medical record entries. If an entry contradicts a previous entry, the author explains the change or contradiction using specific and objective language.
- E. The Attending is responsible for the accuracy, completeness, and timeliness of his/her clinical documentation created independently and/or by his/her Supervisee.
- F. If a Supervisee completes the documentation, the Attending provides a Signature and/or an Attestation of the document within 24 hours of the completion of the documentation by the Supervisee for the Admission History and Physical for patients admitted to Inpatient or Observation Status, Discharge Summary, Consultation Report, and Emergency Department (ED) documentation.
- G. In the event the Attending is unavailable in a timely manner, or is no longer a member of the medical staff, the Chief of Service or his/her designee makes provision for the completion of the medical record.
- H. Specific documentation types and requirements for completion (this list does not include all possible document types within the medical record):
 - 1. Admission History and Physical. The History and Physical serves as the primary source documentation for communicating information to all Providers who are involved in the care of the patient. It contains concise information about the patient's history and exam findings at the time of admission and outlines a plan for addressing the issues which prompted the hospitalization or visit.
 - a. Content requirements include at a minimum:
 - i. Chief complaint and/or reason for admission/observation/procedure;
 - ii. History of present illness;
 - iii. Relevant past medical history;
 - iv. Relevant social history and family history;
 - v. Medications;
 - vi. Allergies;
 - vii. Relevant review of systems;
 - viii. Relevant physical examination;
 - ix. Review of diagnostic data; and
 - x. Diagnosis and treatment plan.

- b. Timeliness requirements are:
 - i. Within 24 hours of admission or placement in observation status; or
 - ii. Within 30 days of admission, placement in observation status, procedure, or operation, provided that an update noting any changes in the patient condition is completed within 24 hours of admission; and
 - iii. Prior to any operation or procedure, and all of the elements noted above are included.
2. Narrative Discharge Summary. The Narrative Discharge Summary serves as the primary source documentation that summarizes the care provided to patients who have been hospitalized.
 - a. Content requirements include at a minimum:
 - i. The Attending at the time of discharge;
 - ii. Reason for admission;
 - iii. Discharge diagnosis(es):
 - 1) All diagnoses treated are included; and
 - 2) A principal diagnosis is identified and represents the primary diagnosis that, after study, was determined to be the cause or reason for the patient's admission;
 - iv. Procedures performed;
 - v. Brief summary of the hospitalization that includes: Pertinent physical, laboratory, x-ray and other diagnostic studies, medical and/or surgical treatment provided, and the patient's response to and any complications from the treatments;
 - vi. Consultations provided;
 - vii. Medications and a reconciled medication list reflecting all medications the patient is advised to take, including any outpatient medications that may have been held during the inpatient stay;
 - viii. Disposition;
 - ix. Condition at time of discharge;
 - x. Information provided to the patient and/or family; and
 - xi. Provider follow-up.
 - b. Timeliness requirements are:

Within 3 days of discharge for all patients discharged, including deaths during hospitalization, except same-day

surgery patients without an overnight stay. Inpatients and patients in observation status require a narrative discharge summary.

3. Brief discharge note:
 - a. Content requirements include at a minimum:
 - i. Attending at the time of discharge;
 - ii. Discharge diagnosis;
 - iii. Medications;
 - iv. Disposition;
 - v. Condition at discharge; and
 - vi. Provider follow-up.
 - b. Timeliness requirements are:
 - i. At the time of discharge; and
 - ii. A narrative discharge summary may be completed in lieu of the brief discharge note provided that the narrative discharge summary is completed at the time of discharge.
4. Consultation report:
 - a. Content requirements include at a minimum:
 - i. Attending physician;
 - ii. Referring physician and service requesting consultation;
 - iii. Reason for consultation;
 - iv. Relevant past histories, examination, and data;
 - v. Diagnostic impression(s); and
 - vi. Recommendations for treatment.
 - b. Timeliness requirements are within 24 hours of consultation.
5. Pre-procedural History and Physical (patient not admitted to inpatient or observation status):
 - a. Content requirements include at a minimum:
 - i. Chief complaint and/or reason for procedure;
 - ii. Relevant past medical history;
 - iii. Relevant social history and family history;
 - iv. Medications;

- v. Allergies;
 - vi. Relevant review of systems;
 - vii. Relevant physical examination; and
 - viii. Signature of the proceduralist with appropriate privileges.
- b. Timeliness requirements are:
- i. Prior to any operation or procedure, and all of the elements noted above are included; and
 - ii. Within 30 days of procedure, provided that an update noting any changes in the patient condition is completed prior to the procedure.
6. Operative report:
- a. General:
- i. Required when surgery is performed in operative location and anesthetic care is provided, **OR**
 - ii. Required if the procedure performed is an extensive or high-risk therapeutic intervention, regardless of location;
 - iii. An Operative Report should be completed if there is uncertainty regarding the extent of documentation required.
- b. Content requirements include at a minimum:
- i. Name/type of operation/procedure;
 - ii. Date of the procedure;
 - iii. Names of all surgeons, proceduralists, and assistants;
 - iv. Preoperative/procedure diagnosis;
 - v. Postoperative/procedure diagnosis;
 - vi. Description of the techniques and procedure;
 - vii. Findings, including notating 'no findings' if none found;
 - viii. Estimated blood loss;
 - ix. Specimen(s) removed, if any, notating 'none' if no specimens removed;
 - x. Complications, if any, including notating 'none' if no complications occurred;
 - xi. Condition of patient; and
 - xii. Prosthetic devices, grafts, tissues, material implanted, if any.

- c. Timeliness requirements are:
 - i. Within 24 hours of the operation, typically created and signed by the responsible Attending.
 - ii. An operative report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. The exception to this requirement occurs when an immediate post-op note is written immediately after the procedure, in which case the full operative report can be written or dictated within 24 hours of the operation. In urgent or emergent situations, if the Attending physician performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the operative report can be written or dictated in the new unit or area of care. The documentation will also clearly indicate that the Attending physician accompanied the patient during the transfer to the next level of care.
 - iii. The Attending's privilege to schedule elective operative cases is suspended for operative reports that are not created within 24 hours.

7. Immediate postoperative note:
 - a. Content requirements include at a minimum:
 - i. Date of operation/procedure;
 - ii. Names of all surgeons, proceduralists, and assistants;
 - iii. Preoperative/procedure diagnosis;
 - iv. Postoperative/procedure diagnosis;
 - v. Name/type of operation/procedure;
 - vi. Case type (Elective, Urgent/Emergent);
 - vii. Findings, including notating 'no findings' if none found;
 - viii. Estimated blood loss; and
 - ix. Specimen(s) removed, if any, notating 'none' if no specimens removed.

 - b. Timeliness requirements are:
 - i. Immediately after the procedure or operation and before the patient moves to another area of care. For more detail, refer to the timeliness requirements for Operative Report in section IV.H.5.b.ii.

- ii. An Attending Signature or Attestation is not required.
- 8. Procedure report:
 - a. General:
 - i. Required for procedures that are diagnostic or therapeutic that are invasive in nature but do not satisfy Operative Report criteria. This includes procedures commonly performed in procedural areas by proceduralists.
 - ii. The following criteria do not determine the procedure report requirement:
 - 1) Procedure location;
 - 2) The patient's level of consciousness or a change in their level of consciousness;
 - 3) The presence or absence of an anesthesiologist.
 - b. Content requirements include at a minimum:
 - i. Procedure performed;
 - ii. Date of procedure;
 - iii. Names of proceduralist(s) and assistants;
 - iv. Indication for procedure;
 - v. Description of procedural technique;
 - vi. Findings (include 'no findings' if none are found);
 - vii. Estimated blood loss;
 - viii. Specimen(s) removed, if any;
 - ix. Complications;
 - x. Type of material implanted, if any; and
 - xi. Type of anesthesia used.
 - c. Timeliness requirements are:

Within 24 hours of the procedure, typically created and signed by the proceduralist.
- 9. Procedure note:
 - a. General: Required when a procedure is performed with the intent to monitor or for diagnostic purposes that is not extensive or high risk to the patient.
 - b. The following criteria do not determine the procedure note requirement:

- i. The presence or absence of an anesthesiologist, including the location of the service provided;
 - ii. Setting, location, or the patient's level of consciousness or a change in their level of consciousness.
 - c. Content requirements include at a minimum:
 - i. Name of the procedure;
 - ii. Date of procedure;
 - iii. Diagnosis;
 - iv. Indications; and
 - v. Description of the techniques and procedure;
 - vi. Estimated blood loss (if applicable);
 - vii. Complications, if any, including notating 'none' if no complications occurred;
 - viii. Type of anesthesia used (if applicable);
 - ix. Pertinent lab values (if available).
 - d. Timeliness requirements are:

Within 24 hours of the procedure, typically created and signed by the proceduralist.
10. Progress notes (for patients in the hospital setting):
 - a. Pertinent progress notes are recorded following the patient encounter and are sufficient enough in detail to permit continuity of care and appropriate and safe patient transfer. Each of the patient's known clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.
 - b. Progress notes are documented at least daily by the service of the primary attending.
11. Hospice Patient Class:
 - a. Patients admitted to Hospice Patient Class receive an inpatient level of care and services and documentation must reflect all care and services provided at VUMC.
 - b. Completion of the standard documentation required for an inpatient admission is required for a Hospice Patient Class admission.
 - c. If the patient is transitioned directly from an inpatient status to the Hospice Patient Class, an update note for the history

and physical completed by a VUMC Provider during the initial hospitalization or within 30 days is acceptable.

- d. The Hospice must provide to VUMC a copy of the Hospice Plan of Care and any updates if applicable.

12. Outpatient encounter:

- a. The following documentation is required for each Outpatient encounter with a Provider and is to be completed within 4 business days following the encounter:

- i. Patient identification information, including at a minimum the patient's full name, date of birth, and the VUMC medical record number;
- ii. Date and time of the clinical encounter;
- iii. Outpatient intake screening and assessment;
- iv. Clinic visit note, including a plan of care, as appropriate;
- v. Medication reconciliation;
- vi. Diagnosis and level of service; and the
- vii. After Visit Summary.

Note: When applicable, the following are included in the documentation of the Outpatient encounter:

- viii. Orders; and
- ix. Procedure note.

- b. Outpatient Encounters with no Provider present may require fewer or different elements of documentation as outlined in IM 10-20.20, [Documentation Standards in the Medical Record](#).

13. Telehealth encounters:

- a. Encounters provided via telehealth real-time audio-visual or audio-only platforms follow all applicable provisions of this policy. Telehealth encounters have the same minimum documentation requirements that are required for an in-person service.
- b. The following additional elements must also be documented for each telehealth encounter:
 - i. A confirming statement that the service was performed via telehealth.

- ii. The patient’s consent to the service being performed via telehealth.
 - iii. The specific telehealth communications platform used to conduct the service. See [IM SOP Approved Telehealth/Teleconferencing Systems](#) for the list of VUMC-approved communication systems.
 - iv. The physical location of the patient during the telehealth service, to include:
 - 1) State; and
 - 2) Whether the patient was in their home; and
 - 3) The name of the facility used as the patient’s originating site during the telehealth service, where applicable.
 - v. The names of any residents, fellows, students, or other VUMC trainees listening in on the telehealth service as part of their educational program.
 - vi. For a billable audio-only encounter, the Provider must document the duration of the phone discussion in minutes.
 - c. Timeliness requirements are:

Identical to those as if the service had been performed in house. See the applicable documentation type section herein for specific requirements.
- 14. Anesthesia documentation –These requirements apply to the provision of anesthesia by qualified individuals.
 - a. A pre-anesthesia evaluation including clinically appropriate history and physical is completed and documented within 48 hours prior to surgery or procedure utilizing anesthesia services. This is required in addition to the proceduralist’s History and Physical for the procedural encounter and cannot be considered to also serve as the proceduralist’s History and Physical documentation.
 - b. An intraoperative anesthesia record.
 - c. Documentation that indicated post-anesthesia care was provided.
 - i. For care areas without a protocol for discharge from the post-anesthesia or post-sedation care area according to discharge criteria, the Provider must document that the patient met criteria to be discharged from the post-anesthesia care unit or

- document that the patient was transferred to the appropriate level of care if not recovered.
 - ii. For care areas with a protocol for discharge from the post-anesthesia or post-sedation care area according to discharge criteria, the Provider is not required to duplicate nursing documentation that the patient has met discharge criteria.
 - d. Documentation of a post-anesthesia visit and evaluation. This can be performed by any qualified anesthesia Provider. The required elements include identification of unfavorable reactions to drugs and anesthesia, completed and documented no later than 48 hours after surgery or any procedure utilizing anesthesia services.
- 15. ED clinical documentation requirements for patients treated and released from the ED as well as patients seen in the ED and admitted to VUMC. The patient's Attending Physician at the time of disposition is responsible for documenting disposition of the patient in the medical record.
 - a. Content requirements include at a minimum:
 - i. Pertinent history of the illness or injury, and physical findings, including the patient's vital signs;
 - ii. Diagnostic and therapeutic orders;
 - iii. Clinical observations, and when applicable, including results of treatment;
 - iv. Reports of procedures, tests, and results;
 - v. Diagnostic impression;
 - vi. Conclusion at the termination of evaluation/treatment, including stabilization and final disposition, the patient's condition on discharge or transfer, and any instructions given to the patient and/or family for follow-up care;
 - vii. Complete and detailed documentation of a transfer from the ED to another facility (e.g., patient request, no capability or capacity at VUMC, patient stabilized and able to be transferred) including risks and benefits of transfer, when indicated.
 - viii. A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment or services.
 - b. Timeliness requirements are:
 - i. Documentation must be completed within 24 hours of the patient's emergency care visit.

- ii. Documentation is authenticated by the Provider who is responsible for its clinical accuracy.

I. Management of Deficient and Delinquent Documentation:

1. Documentation is considered Deficient if requirements are not completed as established in this policy, but before 14 days of the triggering event (e.g., admission, consultation, discharge, clinic visit). This includes documentation created by a Supervisee but not signed by the Attending, if Attending signature is required.
2. Documentation is considered Delinquent if requirements established in this policy remain incomplete more than 14 days after the date of the triggering event (e.g., admission, consultation, discharge, clinic visit).
3. When documentation is incomplete for 28 or more days, the non-House Staff Provider will be placed on a Temporary Suspension of Privileges (reference the VUMC Medical Staff Bylaws) until delinquent documentation is completed. The Suspension of Privileges includes:
 - a. Inability to admit patient to any VUMC hospital;
 - b. Inability to schedule OR procedures;
 - c. Inability to submit claims for any professional services; and
 - d. Forfeiture of revenue associated with any delinquent documentation that is deemed unsuitable for claims submission due to lack of content or timeliness of filing requirements/guidelines.
4. Providers (excluding House Staff) with two or more Temporary Suspensions for incomplete documentation in a 6-month period will undergo a Focused Professional Practice Evaluation (FPPE) for cause initiated for a minimum 6-month period. The duration of the FPPE may be extended (but not shortened) at the discretion of the Clinical Service Chief or designee. Failure to complete the requirements of the FPPE may result in corrective action as outlined in Article XIII of the VUMC Medical Staff Bylaws or other disciplinary action, as appropriate.
5. Delinquent documentation that is discovered from an audit, either routine or for cause, will enter escalation in accordance with the communication and escalation protocol, with the exception of documentation that is discovered to be more than 21 days

delinquent, where the responsible Provider will be allowed 14 calendar days to complete the delinquent documentation before a Temporary Suspension of Privileges occurs.

6. In addition to the timeliness monitoring and reporting, random audits of documentation occur regularly to assess for compliance with content requirements for documentation. Identification of noncompliance with content requirements will result in detailed review of content requirements for involved physician(s) or service(s), as appropriate.

V. Endorsement:

Health Record Executive Committee February 2022

Medical Center Medical Board March 2022

VI. Approval:

Marilyn Dubree, MSN, RN, NE-BC 3/19/22
Executive Chief Nursing Officer, VUMC

C. Wright Pinson, MBA, MD 3/18/22
Deputy CEO and Chief Health System Officer, VUMC

VII. References:

The Joint Commission, Comprehensive Accreditation and Certification Manual. (2019). Retrieved via Eskind Digital Library <http://library.vanderbilt.edu/biomedical/search.php?letter=#tab-search-databases>, then search Joint Commission. *Record of Care Standards*

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VUMC Policy Manual. (2022). Retrieved from <https://vanderbilt.policytech.com>.

Clinical Operations Category:
[Clinician Professional Practice Evaluation \[FPPE - OPPE\]](#)

Clinical Practice Category:
[Outpatient Interdisciplinary Plan of Care](#)

Governance Category:

[VUMC Medical Staff Bylaws](#)

Information Management Category:

[Carry Forward of Clinical Information in the Electronic Health Record](#)

[Definition of the Legal Medical Record and the Designated Record Set](#)

[Documentation Standards in the Medical Record](#)

[Electronic Signature: For Documentation in the Medical Record](#)

[Provider Orders](#)

[Communication and Escalation of Deficient & Delinquent Documentation
\(SOP\)](#)

[Clinician Guidance: Physicians and Advanced Practice Providers - Direct
to Patient Telehealth](#)