Vermont Psychiatric Care Hospital Procedure

Medical Records

Revised: X	Date: 04/07/14

1. Medical records will be accurately written, promptly completed, properly filed, and retained and accessible. White out is not to be used at any time in a medical record.

2. The hospital will use a system of author identification and record maintenance that ensures the integrity of authentication, and protects the security of all record entries.

3. Medical records are maintained in their original or legally reproduced form for a period of at least five (5) years, or more if required by state or federal law or regulation (FDA, OSHA, and EPA). After being maintained on site for five (5) years, medical records will be sent to the State Archives and maintained for another five (5) years. At that time, the State Archives will recommend destruction.

4. The hospital has a system of coding and indexing medical records. The system allows for timely retrieval in order to support medical care evaluation and studies.

5. The hospital has procedures for ensuring the confidentiality of patient records. Information from, or copies of records may be released only to authorized individuals, and the hospital ensures that unauthorized individuals cannot gain access to, or alter patient records. Original medical records will be released by the hospital only in accordance with federal and state laws, court orders, or subpoenas.

6. Outside normal business hours, access to the Medical Records Room shall be provided only to individuals authorized to view or remove records, by staff members of the Admissions Department.

7. All entries must be legible and complete, and must be authenticated and dated properly by the person who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

8. Medical records staff shall accept advance directives, including any amendment, suspension or revocation thereof, and DNR orders from any individual, whether or not the individual is a patient at VPCH. Copies of any such advance directives shall be maintained in the person's patient file and noted in the hospital's electronic database.

9. All records must document the following general medical information

    a. A medical history and physical examination completed and documented within 24 hours after admission, or not more than 30 days prior to admission. A history and physical examination (H&P) that was completed up to 30 days prior to admission may be used if the documented H&P is reviewed and updated as needed within 24 hours of admission by a physician who has clinical privileges to perform H&P's at VPCH.

b. Admitting diagnosis.
c. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
d. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.
e. Properly executed consent forms for procedures and treatment specified by the medical staff or by federal or state law to require written patient consent.
f. All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs, and other information necessary to monitor the patient's condition.

10. All records must document the following information specific to the patient's psychiatric care:

a. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized. Specifically, each patient's medical record must contain:
    i. The patient's legal status and any changes to that status during the length of their stay;
    ii. A provisional or admitting diagnosis made at the time of admission, including the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
    iii. The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved;
    iv. The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of discharge settings and family attitudes, and community resource contacts as well as a social history; and
    v. When indicated, a complete neurological examination must be recorded at the time of the admission physical examination. If the neurological exam indicates the need for emergent or urgent neurological care or stabilization, the patient shall be transferred to a general hospital for emergency care.
b. Each patient's medical record must include a psychiatric evaluation that must
    i. Be completed within 24 hours of admission;
    ii. Include a medical history;
    iii. Contain a record of mental status;
    iv. Note the onset of illness and the circumstances leading to admission;
    v. Describe attitudes and behavior;
    vi. Estimate intellectual functioning, memory functioning, and orientation; and
    vii. Include an inventory of the patient's assets in descriptive, not interpretative, fashion.
c. Treatment Plan.
    i. Each patient's medical record must include an individual comprehensive treatment plan based on an inventory of the patient's strengths and disabilities. The written plan must include:
        1. A substantiated diagnosis;
        2. Short-term and long-range goals;
        3. The specific treatment modalities utilized;
        4. The responsibilities of each member of the treatment team; and

5. Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

ii. The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

d. Each patient's medical record must include progress notes recorded by the patient's attending doctor, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Each patient's medical record must document all efforts at discharge planning and a discharge summary. The discharge summary must include a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition of discharge.

Approved by	**Signature**	**Date**
Frank Reed, Commissioner of DMH	Frank Reed	11/29/16