Vermont Psychiatric Care Hospital Policy and Procedure		
Medical Record Composition Policy		
Effective: 12/19/18	Revised: February 2023	Due to Review: February 2025

POLICY

In accordance with state and federal laws and regulations, the Vermont Psychiatric Care Hospital (VPCH) creates and maintains a comprehensive medical record for individuals evaluated or treated at the hospital.

PROCEDURE

Medical Record Requirements:

- Medical records shall be accurately written, properly filed, retained, and accessible.
- Entries must be legible, complete, and must be authenticated and dated/timed by the person who is responsible for ordering, providing, or evaluating the service furnished.
- The author of an entry must be identified and must authenticate their entry. Authentication may include unique signatures, written initials/signature, or computer-tracked entry.
- Abbreviations noted on the *Joint Commission's "DO NOT USE"* list (linked in the reference section below) will not be utilized for documentation throughout the organization to assure the highest quality of care and to prevent medical/health care errors.
- A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
- VPCH uses a system of author identification and record maintenance that ensures the integrity of authentication and protects the security of all record entries.
- Medical records shall be 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.

- VPCH has a system of coding and indexing medical records. The system allows for timely retrieval to support medical care evaluation and studies.
- Documents remaining in paper form are scanned into the electronic medical record upon completion/receipt.
- Medical record entries that require countersigning, are co-signed in accordance with law and regulation.

A complete VPCH medical record will, at a minimum, contain information sufficient to determine the degree and intensity of treatment provided, including the following elements:

- Demographic Information
    - The individual's legal name, address, and date of birth and the name of any legally authorized representative
    - Sex assigned at birth
    - Gender identity
    - Race and ethnicity
    - Initial legal status and any change in legal status
    - Communication needs, including preferred language for discussing healthcare
- Clinical Information
    - The reason(s) for admission for care, treatment, and services as stated by the hospitalized person and/or others significantly involved
    - Results of physical examinations and other consultative assessments/examinations
    - Food/drug allergies (a physical examination completed within 30 days of VPCH admission is admissible)
    - Initial psychiatric and medical diagnosis, diagnostic impression(s), or condition(s). When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.
    - Initial psychiatric evaluation (within 24 hours of admission):
        - Onset of illness and the circumstances leading to admission
        - Medical history
        - Mental status
        - Description of attitudes and behavior

        - Estimation of intellectual functioning, memory functioning, and orientation
        - Inventory of assets in descriptive, not interpretative, fashion
        - History of findings and treatment provided for the psychiatric condition for which the individual is hospitalized
    - Assessment and reassessment findings
    - Conclusions or impressions drawn from the individual's medical history and physical examination
    - Diagnoses or conditions established during the individual's course of care, treatment, and services including complications and hospital-acquired infections and intercurrent diseases.
    - Consultation reports
    - Observations relevant to care, treatment, and services
    - Response to care, treatment, and services
    - Clinical progress notes:
        - Doctor(s) of medicine or osteopathy or other licensed practitioner(s) who are responsible for the care of the individual. Psychiatry progress notes are documented weekly and shall contain recommendations for revisions in the treatment plan as indicated as well as assessment of the individual's progress in accordance with the original or revised treatment plan and efforts made toward discharge.
        - Registered Nurse progress notes are documented at a minimum of once per shift.
        - Social worker(s) or social service personnel involved in the care of the individual including communication with the individual and any external supports and an assessment of discharge settings and family attitudes, and community resource contacts as well as a social history. The frequency of Social Work progress notes is determined by the condition of the individual, but a progress note shall be recorded at least weekly for the first two months of hospitalization and at least once a month thereafter
        - When appropriate, others significantly involved in the individual's active treatment modalities shall document progress notes.
    - Documentation relating to Emergency Involuntary Procedures and Emergency Involuntary Medications.
    - Documentation relating to Court ordered medication orders and

administration.
    - Orders
    - Medications ordered or prescribed
    - Medications administered, including the strength, dose, route, date and time of administration
    - Adverse drug reactions
    - Information relevant to the monitoring the hospitalized person's condition: vital signs, height, weight, blood glucose monitoring, precaution monitoring sheets, radiology and laboratory reports, etc.
    - Individualized and comprehensive treatment plan based on an inventory of the individual's strengths and liabilities that includes:
        - A substantiated diagnosis
        - Short-term and long-term goals
        - The specific treatment modalities utilized
        - The responsibilities of each member of the treatment team
        - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
        - The treatment provided is documented in such a way to assure that active therapeutic efforts are included
        - Revisions to the plan of care
    - Results of diagnostic and therapeutic tests and procedures
    - Advance directives documents
    - Informed consent, when required by hospital policy
    - Medications dispensed or prescribed on discharge
    - Education provided
    - Discharge diagnosis
    - Discharge plan and discharge planning evaluation
- Discharge Summary
    - The reason for hospitalization
    - Procedures performed
    - Care, treatment, and services provided
    - The individual's condition and disposition at discharge
    - Information provided to the individual and/or external supports
    - Provisions for follow-up care
    - Recapitulation of the course of hospitalization and recommendations from appropriate services concerning follow-up or aftercare

References:

- The Joint Commission Official Do Not Use Abbreviation list can be found here.

Approved by	Signature	Date
Emily Hawes Commissioner Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	2/24/2023