Scripps Health Plan

Medical Record Documentation Standards Tip Sheet

Documentation should meet all federal and state legal, regulatory, and accreditation requirements. Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. There are specific elements that reflect a set of commonly accepted standards for medical record documentation.

- Each page or electronic medical record contains a member's name or medical record number (MRN).
- All entries in the medical record contain the author's identification. Author identification may be a signature and/or a unique electronic identifier.
- All entries in the medical record are dated.
- Allergy list and adverse reactions are prominently noted in the medical record. If there are no known drug allergies or history of adverse reactions, this is appropriately noted in the medical record.
- All medications included in the treatment plan for each encounter is present or updated in the medication list.
- Significant illnesses and medical conditions are indicated on the problem list.
- An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
- Past medical history is easily identified in the medical record and includes serious accidents, operations, and illnesses. For children and adolescents (younger than 18 years), the past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- Documentation that members are assessed for risk factors and offered preventive screening, services, and education in accordance with clinical guidelines specific to member's age, gender, or illness, as appropriate, and at recommended intervals according to the USPSTF grade A and B recommendations.
- Documentation that treatment goals were established and communicated to the member.
- Documentation of any barriers regarding member compliance with prescribed treatments and regimens, and interventions on how to address these barriers.
- Documentation that demonstrates continuity and coordination of care between and among providers, including medical, mental health, and maternal mental health providers.
- Documentation demonstrates no evidence that the member is placed at inappropriate risk by a diagnostic or treatment procedure.
- Documentation of an Advanced Directive or counseling offered if member is 18 years old and over.
- If a specialist visit is requested, there is documentation of feedback from the specialist to the primary care physician (PCP) within fourteen (14) calendar days of the specialist visit.
- Clinical documentation matches/supports orders and referrals entered in the EHR system.
- Documentation of all members of the care team can be clearly identified.
- Documentation of care coordination between other providers in the care team is present.

- Medical records should be readily available for release to other treating providers and to support continuity of care.
- Providers should be familiar with additional requirements within their respective medical practices and/or Medical Staff Rules and Regulations for hospital encounters.
  - Amendments, addendums, corrections, or delayed/late entries are to be completed in accordance to *Scripps Health (Epic) Manual Chart Correction Guide* and/or Scripps Health's Health Information Management (HIM) standard work. Refer to *Scripps Health's Health Record, Definition and Management policy; S-FW-RC-0001*.