ORIENTATION
TO THE
HEALTH INFORMATION
MANAGEMENT DEPARTMENT

- ORIENTATION
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ORIENTATION TO THE
HEALTH INFORMATION MANAGEMENT DEPARTMENT

1. LOCATION:

The HIM Department is located in the Tower Building on the first floor.

2. HOURS OF OPERATION:

The HIM Department is open Monday – Friday, 7:00 am – 12:00 midnight. Saturday, Sunday, and Holidays, 8:00 am – 4 pm.
To arrange any appointment for chart completion dial 562-4273.
Service is also available in the Doctor’s Lounge with coffee and Danish.

3. CHART COMPLETION:

   a. North Shore University Hospital takes chart completion very seriously. It is your responsibility to complete your charts on a timely basis. The New York State Department of Health as well as the Joint Commission require charts to be completed within 30 days of discharge. Discharge Summaries should be completed immediately following a patient’s discharge and Operative Reports have to be dictated immediately following a procedure.

   b. You will be notified by the HIM Department via fax if you have 4 or more delinquent charts on the Monday of a given week. If by Thursday of that week you have not completed your charts, a second fax will be sent to you by the HIM Department warning that your name will be submitted to your Chairman for possible suspension if you do not complete your charts by Friday of that week. It is expected that after you are notified that you will complete your charts by the end of the week. Simply call the HIM Department at extension 4273 or 4593 and request to have your charts pulled and they will be ready and waiting for you when you come in to complete them.

   c. Your cooperation in completing your charts as soon as possible is imperative if the hospital is to remain compliant with regulatory agencies such as the Department of Health and the JCAHO.

4. DOCUMENTATION GUIDELINES: (see packet insert #1)

In addition to the information supplied in insert #1, please be aware of the following:
a. If it is not documented in the medical record, it did not happen. Please make sure to document all pertinent information.

b. **Never use whiteout.** The accepted technique for making a correction is to place a single line through an error, initial it and then write the correction.

c. Never remove any documentation from a patient’s medical record.

d. Signatures should be legible with your credential noted.

e. All entries must be dated, legible and clear.

f. Addendums are acceptable but must be dated the date of entry.

5. **DICTATION OF OPERATIVE REPORTS:** (see insert #2)

Please review these guidelines so that you are familiar with the required content and format of these reports prior to dictating.

6. **INSTRUCTIONS FOR DICTATING:** (see insert #3)

Please review this document for directions. In addition, the following information is offered:

a. You will be given a dictating card with your access number to be used once you dial in to dictate.

b. Dial 562-2990 to gain access to the dictating system outside the hospital.

c. From within the hospital you only need to dial the extension 2990.

d. If you experience any difficulty in dictating, please hang up and dial 562-4273 and the HIM Department will help you.

7. **NORTH SHORE UNIVERSITY HOSPITAL ACCEPTABLE SYMBOLS AND ABBREVIATIONS:** (see insert #4)

Please review this document for acceptable symbols and abbreviations. If it is not in this listing, it is not acceptable and should not be written in the chart.

8. **REQUESTING A CHART FOR PATIENT CARE:**

To obtain a chart for patient care, you may either call extension 4260 or come in to the HIM Department with the following information:

i. Patient’s Name
ii. Medical Record Number
iii. Location of the Patient (if in-house)

The chart will be located and you will be paged when it is available.

9. **ADDITIONAL INFORMATION:**

   a. Medical Records are **never** to be removed from the hospital building.

   b. If a patient is in the hospital, his/her chart must remain with the patient at all times and **is not to be removed from the floor** unless it is being sent with the patient for a test or procedure.

   c. Missing medical records put the hospital at high risk for litigation and loss of reimbursement. Please assist us in eliminating both by not removing charts from designated areas.

   d. The Health Information Management Department is here to assist you. If you have any questions, please do not hesitate to contact us at extension 4260.
**History & Physical Examination:** (Source: Medical Staff Rules & Regulations, Section D, Parts 1, 3, 5)

- Upon **admission**, the Attending Physician, Dentist or Podiatrist must document a medical History and Physical examination relevant to the patient’s presenting signs and symptoms, as well as summary note including a provisional diagnosis, the patient’s status and a preliminary treatment plan.

- The H&P shall include a screening uterine cytology smear on women 21 years or older, unless the test is medically contraindicated or has been done within the past three years.

- A medical H&P is to be completed within 24 hours of admission.

- The Emergency Room H&P does not suffice for an inpatient admission H&P. A comprehensive H&P is required when the patient is admitted.

- A complete H&P, submitted to the Hospital from an outside physician, may be acceptable if it has been performed within seven days of admission.

- An H&P may be documented by a Resident, Physician’s Assistant, Nurse Practitioner, Attending Physician, or Dentist.

- If the H&P is written by a Resident, Physician’s Assistant (PA), or Nurse Practitioner (NP), it **MUST** be countersigned by the Attending Physician, Dentist or Podiatrist prior to the patient’s discharge.

- When the H&P is not completed and signed by an Attending Physician, Dentist or Podiatrist before a surgical procedure, THE PROCEDURE IS TO BE CANCELED (unless the risk of delay is overriding).

- Any entry made in the medical record by medical or dental students must be countersigned within 24 hours by the Attending Physician, Dentist or Podiatrist (as applicable), or by a supervising Resident at least at PGY level 2 and licensed as a physician (or dentist) in New York State.
**Advance Directives:** (Source: Patient Care Standard Policy and Procedure “Patient Assessment: Initial and Ongoing”), also: Administrative Policy and Procedure 100.28 “Patient Advance Directives” and Administrative Policy and Procedure 100.24 “DNR Orders”

- Any patient over the age of 18, including emancipated minors, must be screened for Advance Directives upon admission.
- Patients must be asked if they have Advance Directives and the answer recorded in the medical record. All sections pertaining to advanced directives are to be complete in the EHR.
- A copy of the patient’s directive(s) is to be placed in the paper record.
- Patients “with capacity” who come to the facility with a DNR previously filed out is a valid Advance Directives, so long as the physician discusses the DNR with the patient and documents a note and writes a DNR order in the medical record.
- Patients “without capacity” who come to the facility with a DNR previously filled out is valid as an Advance Directives, so long as the physician fills out the DNR form stating “Without Capacity” and has a copy of the patient’s DNR for filing in the medical record.

**Physician Orders:** (Source: Medical Staff Rules & Regulations, Section F, Parts 2, 3, 4)

- Regarding Orders (including telephone orders):
  - Orders may be issued by practitioners appropriately credentialed by the Medical Board (i.e. Attending Physician, Dentist, Podiatrist or Resident, Nurse Practitioner, Physician Assistant, Nurse Midwife or Nurse Anesthetist).
  - Telephone Orders may be issued by:
    - Medical Staff
    - Graduate Staff
    - Nurse Practitioner
    - Certified Nurse Anesthetist
    - Physician Assistant
    - Nurse Midwives
  - Telephone Orders are to be entered into the EHR by the receiving RN.
  - Authentication Requirement: Telephone/Verbal Orders must be “ready back” for verification, dated, and signed by the issuer as soon as possible, but within 30 days of discharge.
    - **Exception:** Orders for Controlled Substances must be signed within 48 hours (New York State regulations state that controlled substances ordered by a Physician Assistant must be signed within 24 hours)
• Regarding Verbal Orders:
  o Verbal Orders may only be issued during an emergency by a member of the Medical Staff, Graduate Staff or Nurse Midwife
  o Verbal Orders can only be accepted by:
    • Allied Health Professions Adjunct Staff (see above)
    • A Pharmacist
    • Registered Nurse
  o Authentication Requirement: Telephone/Verbal Orders must be “read back” for verification, dated, and signed by the issuer as soon as possible, but within 30 days of discharge.
    • Exception: Orders for Controlled Substances must be signed within 48 hours
  o Restraints: refer to policy – Patient Care Services P&P Manual: “Restraints”

**Anesthesia:** (N/A for Pediatrics)

• Consent for Anesthesia
  o An Informed Consent discussion is documented on the second side of the Anesthesia Record. It is documented by the Anesthesiologist and must contain a description of the anesthesia risks, benefits, alternatives and the anesthesia plan.

• Reassessment prior to induction of anesthesia
  o This is noted on the second side of the Anesthesia Record where is specifically states “Status change from pre-op”

**Operative:** (N/A for Pediatrics)

• An Informed Consent must be signed and dated by the patient and physician
• The Operative Report must be dictated immediately following surgery and the Face Sheet indicator signed when the report has been dictated
• A brief Operative Note, containing the following, must be recorded in the Progress Notes immediately following surgery:
  o Name of Surgeon
  o Name of First Assistant
  o Name of Procedure
  o Post-operative Diagnosis
  o Specimen Removed
• H&P must be countersigned by the Attending Surgeon preoperatively if the H&P has not been signed by an Attending Physician

**General:** (Source: Medical Staff Rules & Regulations, Section E, Part 8)

• Any entry made in the medical record by medical or dental students must be countersigned within 24 hours by the Attending Physician, Dentist or Podiatrist (as applicable) or by a supervising Resident at least at PGY level 2 and licensed as a physician (or dentist) in New York State.
Admission Documents:

• A final diagnosis shall be recorded in the EHR, and signed by the responsible physician at the
time of discharge of all patients.
• A General Consent form titled “Consent For Admission and Treatment” must be signed and
dated by the patient and witness.
• A document titled “Authorization For Release of Information” must be filled out by the
patient as this document, when signed by the patient, authorizes release of records.

Discharge Summary (Final Summary):  (Source: Medical Staff Rules & Regulations, Section E, Part 9)

• Residents and Allied Health Professionals Adjunct Staff, including Podiatrists, Physician
Assistants, Nurse Practitioners and Nurse Midwives (who are appropriately credentialed and
privileged) may complete Discharge Summaries in the EHR, provided that such Discharge
Summaries are reviewed and countersigned by the appropriate Attending Physician of record.

Transfers between Syosset and Manhasset:

• Transfers between Syosset and Manhasset or Manhasset and Syosset are treated the same as
any patient transferred from one unit of a hospital to another unit in the SAME hospital.
• This is unique to Syosset and Manhasset because these facilities share one operating license.
• The original medical record transfers with the patient, as would be the case with any in-house
transfer.
• The original medical record remains at the facility where the patient was ultimately
discharged from.
Dear Doctor:

Your assistance is necessary in completing the required elements listed below. In order for the hospital to be compliant with the Joint Commission on Hospital Accreditation of Health Care Organizations, we must have a current record of your signature on file.

Please fill out the data below and return this form in the stamped, self-addressed envelope provided.

Your anticipated cooperation in this matter is appreciated.

PRINT NAME: ________________________________________________

SIGN NAME: ________________________________________________

Do you utilize a signature stamp? _____ yes _____ no

If yes, please complete the following statement:

I acknowledge that I am the only individual with access to my signature stamp and am the only one authorized to use this stamp.

ORIGINAL SIGNATURE: _______________________________________

SIGNATURE IMPRINT: _________________________________________

Do you utilize an electronic signature? _____ yes _____ no

If yes, please sign here to indicate that you are the only individual authorized to use your electronic signature: ________________________________________