North Shore LIJ Health System
270-05 76th Avenue
New Hyde Park, NY 11420

HEALTH INFORMATION MANAGEMENT DEPARTMENT
270-05 76th AVENUE, NEW HYDE PARK, N.Y. 11040
OFFICE- (718) 470-7435, FAX- (718) 470-6202, LIJHIMchartcompletion@nshs.edu

Welcome to the Health Information Management Department (Medical Records)

Hours of Operation:

Physician's Chart Completion Area/Transcription (718) 470-7450
LIJ Main 1st fl rm. M-1095 Monday – Friday 7:00 a.m. – 7:00 p.m.
Supervisor: Parminder Kaur (718) 470-7449 is available Monday – Friday 9:00 a.m. – 5:00 p.m.
The dictation system is available 24 hours per day, 7 days per week by dialing (718) 470-4444, or extension 4444 from within the hospital. Any questions regarding dictations, transcribed reports, and physicians chart completion activities including physicians queries, should be referred to the supervisor.

Release of Health Information Unit (718) 470-7329
LIJ Main 1st fl rm. 1094 Monday – Friday 8:00 a.m. – 5:00 p.m. No weekend service.
Supervisor Daljit Kaur (718) 470-7276 is available Monday – Friday 9:00 a.m. – 5:00 p.m.
Any questions regarding *Release of Information* (ROI) should be referred to the supervisor.

LIJ Main Area/Chart Assembly & Retrieval (718) 470-8429
G-Level: G-004 -- 24 Hours
Supervisor: Steve Sfikas (718) 470-4477 is available Monday – Friday 8:00 a.m. – 4:00 p.m.

Administrative Offices (718) 470-7435
LIJ Main 1st fl rm. 1094 Monday – Friday 9:00 a.m. – 5:00 p.m.
Associate Director: Lordy Josama (718) 470-7442 is available Monday – Friday 8:30 a.m. – 5:30 p.m.
Administrative Assistant: Anna Wong (718) 470-7634 is available Monday – Friday 9:00 a.m.- 5:00 p.m.

Medical Records Committee (M.R.C.)
Occurs: 2nd Monday of every month
Chaired by: Francis J Macchio, MD Dept. of Anesthesiology, LIJMC (718) 470-7390 fmacchio@northwell.edu
Deborah Mensch, MD Chief Medical Information Officer, CCMC (718) 470-7350 dmensch@northwell.edu

Forms (FOD) Coordinator: Anna Wong (718) 470-7634 is available Monday – Friday 9:00 a.m.- 5:00 p.m.

- All forms and stamps, which are to be placed in the medical record, require prior approval of the Medical Record Committee and ratification by the Medical Board.
- The "Forms Impetus" questionnaire needs to be completed for all new and revised forms.
- All forms must conform to the hospital forms template standards including using acceptable symbols & abbreviations.
- For a list of Approved & Un-approved symbols & abbreviations, please visit our INTRANET page:
  - **https://nslijhp.northshorelij.com/employees/Pages/default.aspx**
- The above shall also apply to all forms/stamps/stickers being piloted.
- In the event that a form needs to be expedited, the MRC Chairs or the H.I.M. Director needs to be consulted as soon as possible.

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GENERAL MEDICAL RECORD KEEPING PRINCIPLES

A complete medical record is maintained on all patients. Upon discharge, the entire record will be assembled into a permanent unit record which contains the specific information needed to justify the diagnosis and course of treatment. The patient's medical record is the lawful property of the institution and is never to be removed from its premises unless it is for legal purposes or is authorized by the Medical Director, Executive Director or appropriate designee.

In accordance with the Rules & Regulations of the Medical Staff, Joint Commission standards, and the Department of Health regulations, medical records are to be completed timely but no more than 30 days following patient's discharge. Operative reports are to be dictated immediately following surgery and, according to hospital's Rules & Regulations, must be authenticated and signed within 7 days of the procedure.

The physician of record shall edit, correct, or amend and countersign the history, physical examination, Discharge Summary, created by a Resident, Physician Assistant or Nurse Practitioner.

The H.I.M. Department is responsible to monitor all medical records for appropriate documentation. Individuals authorized to document in the medical record, using ***black ink ball point pens***, are as follows:

- Credentialed members of the Medical Staff, i.e. Attending Physicians, House Officers, Residents, Fellows, PA's
- Registered Nurses / Nurse Practitioners / Nursing Assistants, Registered Dieticians, Respiratory/Physical Therapists
- Social Workers, Unit Receptionists / other ancillary staff as deemed appropriate
- **All entries must be timed, dated and authenticated** by the author's signature and beeper/identifying code, either manually or electronically.
- In the event of death, a summation statement shall be made as to the immediate cause of death.
- It is never acceptable to use pencils, colored pens, markers or any other unapproved writing instrument within the medical record.
- Errors within the medical record are to be corrected in accordance to Medical Board rules & regulations and industry-wide standards. It is never acceptable to: ***White out, Scribble out, Write over, Tear out a page (s), Squeeze in*** a note. To correct an error, within a medical record, the author must:
  - *Put a single line through the error.*
  - *Label it "Error"*
  - *Date, time and initial the correction.*
- If a provider wishes to add information (addendum) which has been omitted, he or she must:
  - Enter a note in the next available space.
  - Label it "Addendum".
  - Document date and time that entries were made.
  - Document the omission.
  - Sign the entries.

History and Physical Examinations:

The H&P is recorded at the time of the patient's admission or within 24 hours of admission or prior to the performance of surgery and must include:

- Chief complaint;
- Details of the present illness;
- Relevant past, social and family history;
- Allergies;
- Review of systems;
- Physical examination to include inventory of body systems and vital signs;
- Pelvic, rectal, breast and for diabetic patients, funduscopic examination or reason for deferral, along with results if done in the hospital;
- Conclusions or impressions;
- Course of action or plan.
- Treatment plan;

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Progress Notes:

- Must be timed, dated, signed and **written on a daily basis**. (JC / Rules & Regs)
- Should give a pertinent chronological report of patient's course, and reflect any change in condition, and results of treatment.

Consultation:

- Must be dated and timed.
- Should contain written opinion reflecting actual examination of the patient and the patient's medical record.
- Dated/Timed/Signed by both the provider requesting the consult and the specialist completing the consult.

Operative Reports:

- History and physical examination must be on the chart prior to the surgical procedure, and patient re-assess immediately prior to induction.
- Immediately following surgery, an operative report must be dictated or a progress note written before the patient is transferred to the next level of care.
- Must include: *Name of the procedure/operation, Preoperative diagnosis, Postoperative diagnosis, Name of primary surgeon and any assistants, Description of the findings, Technical procedures, Specimens removed, Condition after surgery, Estimated Blood Loss.*

Discharge Summary or Final Summary:

- Must recapitulate the reason for the hospitalization (Admitting diagnosis/reason for admission)
- Hospital course; consultants
- Must include final diagnosis and any associated diagnosis;
- Must include significant lab/history and pertinent physical findings.
- Must include procedures performed and treatment rendered.
- Must include the condition of the patient on discharge.
- Must include any discharge instructions relating to physical activity, medication, diet and follow-up care. Discharge medications;
- Final progress note may be substituted for a discharge summary if:
  - The patient was hospitalized less than 48 hours for a minor problem (does not include deaths).
  - The patient had an uncomplicated obstetrical stay, or was a normal newborn infant.
- Final progress note should include instructions to the patient and/or family.
- A copy of the discharge instructions given to the patient is filed in the medical record

INCOMPLETE MEDICAL RECORDS

Physicians are required to complete all medical records made available to them. Physicians will be eligible for suspension if:

- *They have any un-dictated/un-signed Operative Reports 7 days after patient's procedure.*
- *They were not on vacation prior to the suspension list being generated.*
- *Courtesy phone calls are made to physicians as a reminder to dictate/complete their outstanding reports.*
- *Once on suspension, physicians are prohibited from booking new elective cases but are allowed to operate on previously scheduled patients, and/or to provide emergency care.*
- *Suspended physicians are not permitted to admit or book their patients under other colleagues within the same group as a result of their suspension.*
- *Surgeons are not permitted to book any new cases unless given a written reprieve by Administration, Department Chairperson, and/or H.I.M. Director, or unless it is an Emergency surgery (Expected to operate within 2-4 hours from Emergency Room visit).*
- The physicians' privileges will be reinstated and re-activated in the hospital information systems once all delinquencies are satisfied.