LaFleur Brooks' Health Unit Coordinating

7th edition

Chapter 08

The Patient's Chart or Electronic Medical Record

Lesson 8.1

Purposes and Uses of the Electronic Medical Record and Paper Chart

1. Define the terms in the vocabulary list.
2. Write the meaning of the abbreviations in the abbreviations list.
3. List six purposes for maintaining an electronic medical record (EMR) or paper chart for each patient.

Lesson 8.1

Purposes and Uses of the Electronic Medical Record and Paper Chart (cont'd)

4. Demonstrate knowledge of military time by converting military time to standard time and standard time to military time.
5. List five guidelines to be followed by all personnel when entering information into a patient's EMR.
6. Describe how the patient's medical records are organized and identified when paper charts are used and list five guidelines to be followed by all personnel when writing on a patient's paper chart.

Lesson 8.1

Purposes and Uses of the Electronic Medical Record and Paper Chart (cont'd)

7. Identify four standard patient chart forms that are initiated in the admitting department.
8. State the purpose of seven standard chart forms included in a patient's electronic or paper admission packet and list information that is included on the history and physical form.

Purposes of a Patient's EMR or Paper Chart

- Means of communication
- Documentation and planning of patient care
- Research
- Education
- Legal record/document
- History of patient illnesses, care, treatment, and outcomes

Military Time

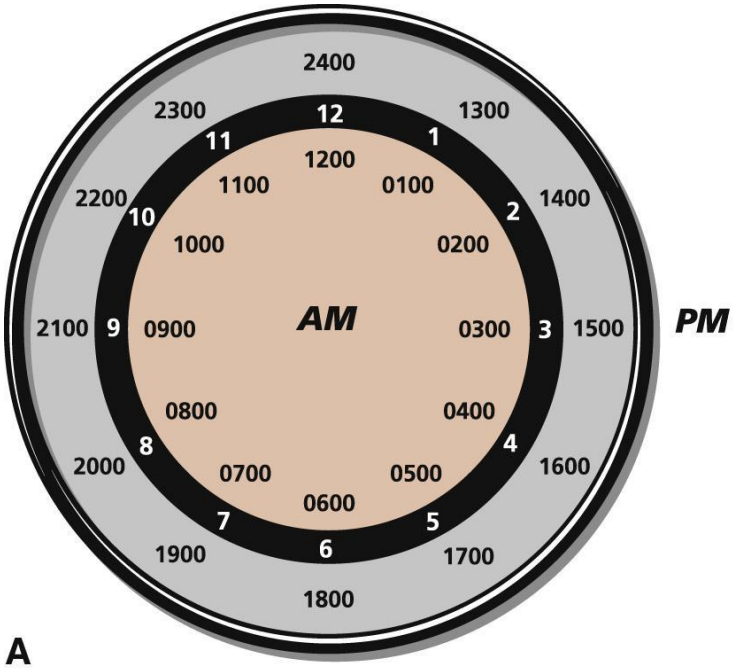
- A system that uses all 24 hours in a day (each hour has its own number) rather than repeating hours and using am and pm.
- When using military time, there are always four digits, the first two digits representing hours and the second two representing minutes.
- The colon is not needed when military time is used.
  - E.g. 1:45 pm = 1345
- Military time is used with the EMR and paper chart systems.

Standard and Military Time Comparisons

TABLE 8-1 Standard and Military Time Comparisons

Standard Time	Military Time	Standard Time	Military Time
12:15 AM	0015	1:00 PM	1300
12:30 AM	0030	1:15 PM	1315
12:45 AM	0045	1:30 PM	1330
1:00 AM	0100	1:45 PM	1345
2:00 AM	0200	2:00 PM	1400
3:00 AM	0300	3:00 PM	1500
4:00 AM	0400	4:00 PM	1600
5:00 AM	0500	5:00 PM	1700
6:00 AM	0600	6:00 PM	1800
7:00 AM	0700	7:00 PM	1900
8:00 AM	0800	8:00 PM	2000
9:00 AM	0900	9:00 PM	2100
10:00 AM	1000	10:00 PM	2200
11:00 AM	1100	11:00 PM	2300
12:00 Noon	1200	12:00 Midnight	2400

24-Hour Clock and Military Time



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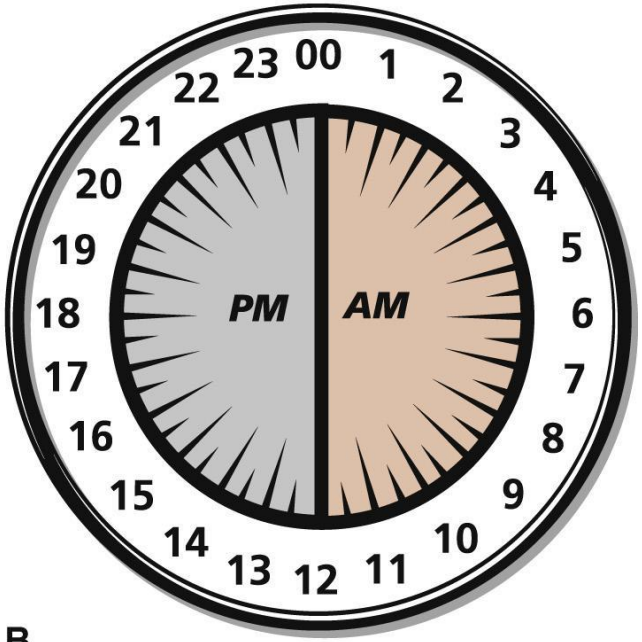


B

Confidentiality

- The EMR or paper chart is confidential.
- The HUC is the custodian of all patient medical records (electronic or paper) on the unit.
- All health care personnel are required to have a code and password to gain access to a patient's EMR.

Entering Information into EMR

- Guidelines:
  - All entries into the EMR must be accurate.
  - Handwritten progress notes, reports, consents, and reports must be scanned into the EMR.
  - Errors made in care or treatment must be documented and cannot be falsified.
  - All entries into the EMR must include the date and time (military or traditional) of the entry.
  - Abbreviations may be used in keeping with the health care facility's list of "approved abbreviations."

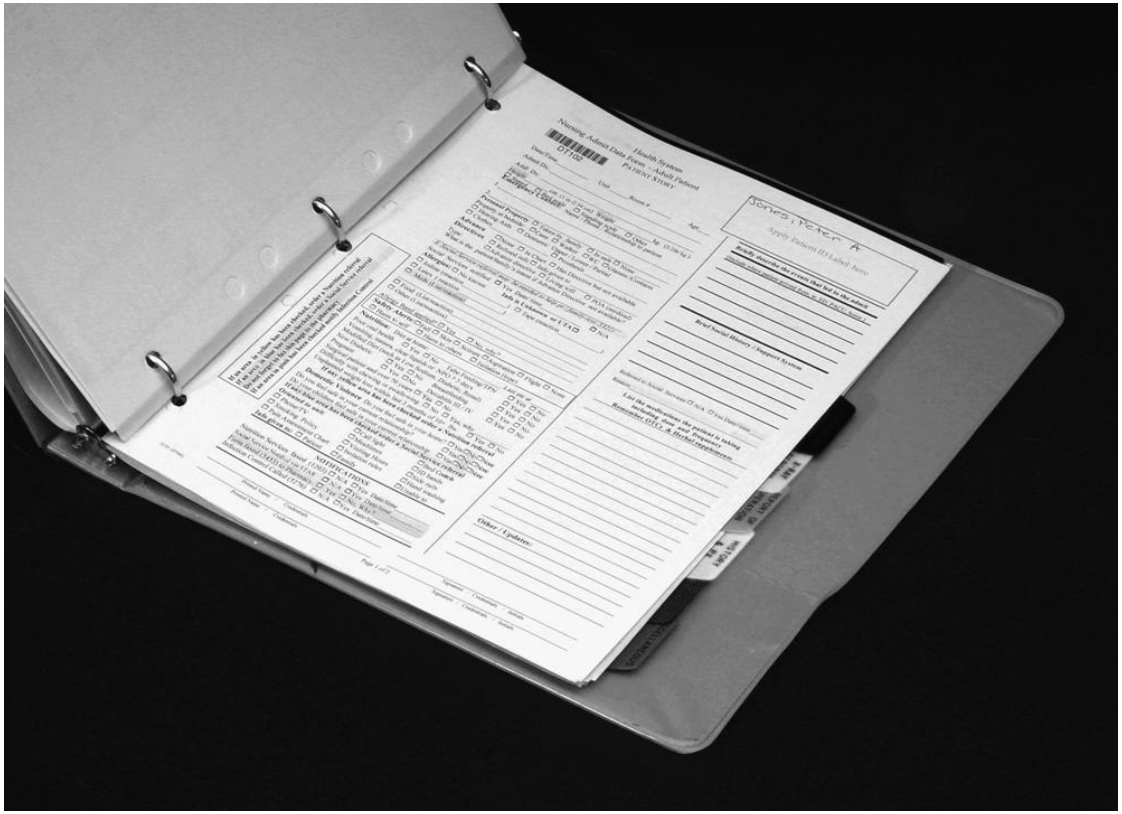
Entering Information into Paper Chart

- Guidelines:
  - All paper chart form entries must be made in ink. This is to ensure permanence of the record.
  - Written entries on paper chart forms must be legible and accurate. Entries may be made in script or printed.
  - Recorded entries on the paper chart may not be obliterated or erased.
  - All written entries on paper chart forms must include the date and time (military or traditional) of the entry.
  - Abbreviations may be used in keeping with the health care facility's list of "approved abbreviations."

Organization and Identification of Patient Charts

- Chart Binder
  - Forms are usually kept together in a three-ring binder that may open from the bottom.
- Chart forms
  - Sectioned off by dividers placed in the chart according to the sequence set forth by the health care facility
- Room and bed numbers may be written on the outside of the chart binder.

Paper Chart with Dividers



Patient Chart Binders Properly Labeled

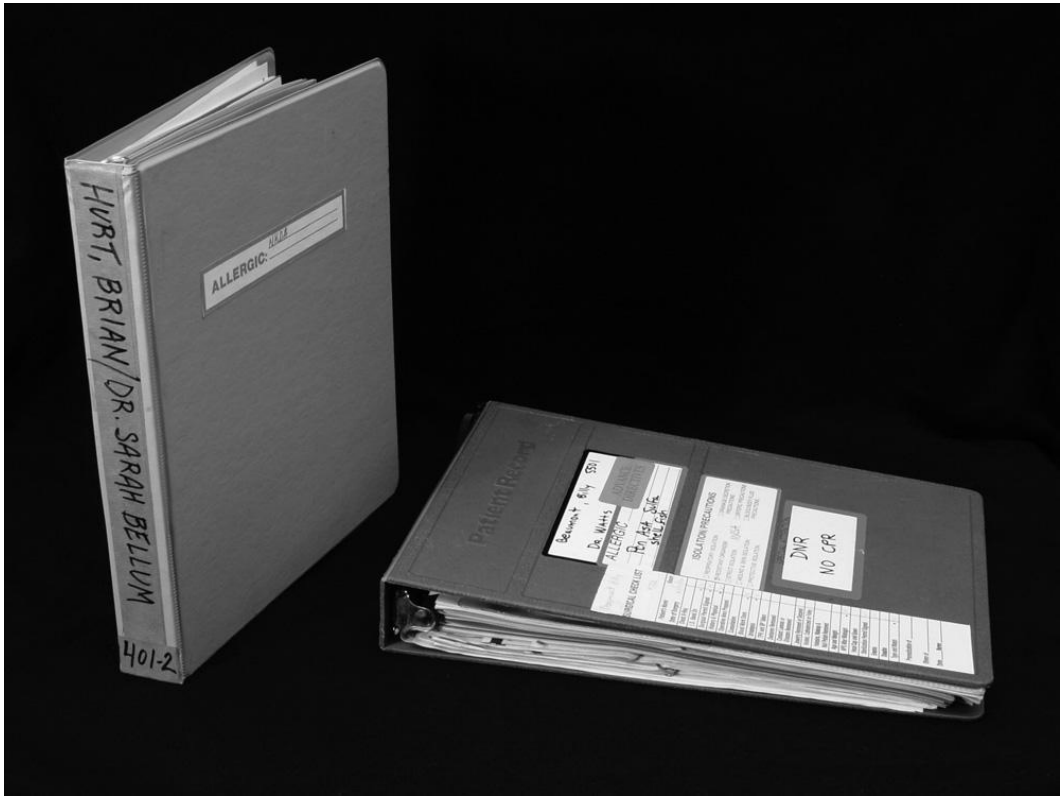


Chart Racks

- One type allows patient paper charts to be placed in a chart rack in which each slot on the rack holds one patient chart.
  - Slots are labeled with the room and bed numbers.
- Another type of chart storage is a WALLaroo.
  - A locked workstation that is located on the wall outside the patient's room
  - It stores a patient's paper chart or a laptop computer and, when unlocked, forms a shelf to write upon.

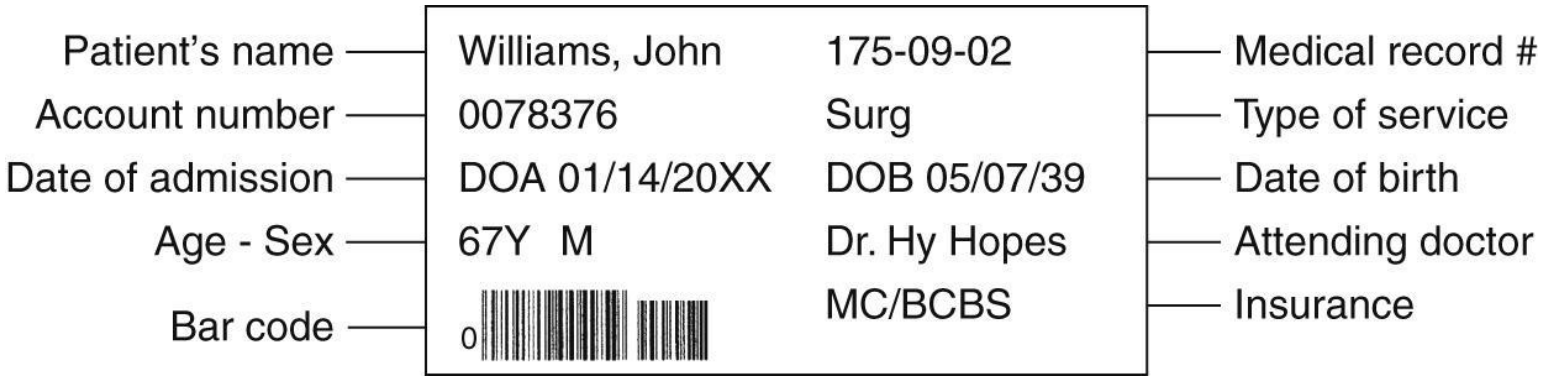
Example of a Chart Rack

Example of a WALLaroo

Patient Identification Labels

- Packet of labels printed upon admission to hospital
- Information on the identification labels includes:
  - Patient's name, age, sex, account number, health record number, admission date, and attending physician's name
- A bar code may be included for identification purposes.
- Labels may be generated from the computer and printed on a label printer.

The Patient Identification Label



Standard Paper Chart Forms Initiated in the Admitting Department

- Face Sheet or Information Form
- Admission/Service Agreement Form (also called Conditions of Admission [COA])
- Patient's Rights (Patient receives copy.)
- Advance Directives (scanned into patient's EMR)

Face Sheet/Information Form

- Originate in the admitting department
- Sent to the unit to be placed in the chart
- Face sheets are taken by the attending physician and by consulting physicians to be used for billing purposes.

Admission/Service Agreement Form

- Signed by the patient in admitting and then scanned into the patient's EMR
- Gives legal permission to the hospital/doctor to treat the patient
- Serves as a financial agreement

Advance Directive Checklist Form

- Documents that a patient has been informed of their choice to declare health care decisions
- After being signed, it is sent to be scanned into patient's EMR.
- Self-Determination Act of 1990 mandates that all patients admitted to a health care facility must be asked whether they have or wish to have an advance directive.

Standard Paper Chart Forms Included in Admission Packet

- Physician's order form
  - Used by doctor to request care and treatment procedures for the patient
- Physician's progress notes
  - The physician records the patient's progress during the patient's hospitalization.
- Nurse's admission record
  - A short nursing history from the patient or family member, patient's vital signs, height, weight, and any allergies to food or medications

Standard Paper Chart Forms Included in Admission Packet, cont'd

- Nurse’s progress notes/flow sheet
  - Used to outline patient’s care; record treatment, progress, and activities of the patient
- Medication administration record (MAR)
  - Used to record all medications given by nursing personnel (electronic or paper)
- Nurse’s discharge planning form
  - Used to prepare the patient for discharge from the health care facility
- Physician’s discharge summary (DRG sheet)
  - Used by the physician to summarize treatment/diagnosis – includes discharge info

Standard Patient Chart Form Initiated by the Physician

- History and Physical Form
  - Used to record the medical history and the present symptomatic history of the patient
  - A review of all body systems or physical assessment of the patient is also recorded.

Lesson 8.2

Management of Forms and Maintenance of the Electronic Medical Record and Paper Chart

9. Define what is meant by a supplemental chart form and provide at least two examples of supplemental chart forms.
10. Explain the importance of accurately charting vital signs in a timely manner and explain the correction of three types of errors on a graphic record.
11. Describe the purpose of a consent form and list five guidelines to follow in the preparation of a consent form.

Lesson 8.2

Management of Forms and Maintenance of the Electronic Medical Record and Paper Chart (cont'd)

12. List four types of permits or release forms that patients may be required to sign during a hospital stay.
13. Describe the methods for correcting a labeling error and a written entry error on a patient's paper chart form.
14. List seven health unit coordinator (HUC) duties in monitoring and maintaining the patient's EMR.

Lesson 8.2

Management of Forms and Maintenance of the Electronic Medical Record and Paper Chart (cont'd)

15. List eight HUC duties in maintaining a patient's paper chart.
16. Explain the purpose and process of splitting or thinning a patient's chart and reproducing chart forms.

Supplemental Chart Forms

- Additional to the standard chart forms according to specific care and treatment provided:
  - Clinical Pathway Record Form
  - Anticoagulant Therapy Record
  - Diabetic Record
  - Consultation Form
  - Operating Room Records
  - Therapy Records
  - Parenteral Fluid or Infusion Record
  - Graphic Record Form

Graphic Record Form

- Used to graph patient TPR, I & O
- Daily weights are also recorded on the graphic record form.
- Usually included in nurses' notes and completed by patient's nurse
  - Some hospitals' vital signs are completed by the HUC on a separate form.
- Accuracy and timeliness in recording of vital signs information is a must.
  - Doctor may use this information to prescribe treatment for patient.

Correcting Errors on the Graphic Record in Paper Charts

- Errors may not be obliterated or whited out as the graphic records are legal documents.
- Minor errors can be corrected on the original graphic record.
- If a major error needs to be corrected, follow procedures in Box 8-3

Consent Forms

- A number of conditions require the patient or a responsible party to sign a special form granting permission for surgery or other invasive procedures to be performed on the patient.
- A consent form should not be signed until:
  - The physician has explained the surgery or invasive medical procedure.
  - Its risks, alternatives, and likely outcomes (informed consent) are explained.
- After receiving an explanation, a competent patient can give their informed consent.

Procedure for Preparing Consent Forms

- Affix the patient's ID label to the consent form.
- Write in black ink the first and last names of the doctor who is to perform the surgery or invasive medical procedure.
- Write in black ink the surgery or invasive medical procedure to be performed exactly as the physician wrote it on the physician's order sheet.
    - Abbreviations must be spelled out.

Procedure for Preparing Consent Forms, cont'd

- Spell correctly and write all information legibly.
- Do not record the date and time.
  - The person who obtains the patient’s signature will enter the date and time.

Four Other Types of Release Forms

- Situations that require a release form during hospitalization:
  - Release of side rails
  - Consent to receive blood transfusion
  - Refusal to permit blood transfusion
  - Consent form for human immunodeficiency virus (HIV) testing

General Rules for Signing Consent Forms

- Personnel must follow these general rules when asking patients to sign consent forms:
  - The patient must not be under the influence of any “mind-clouding” medications.
  - The patient must be of legal age (18 years in most states).
  - The patient must be mentally competent.

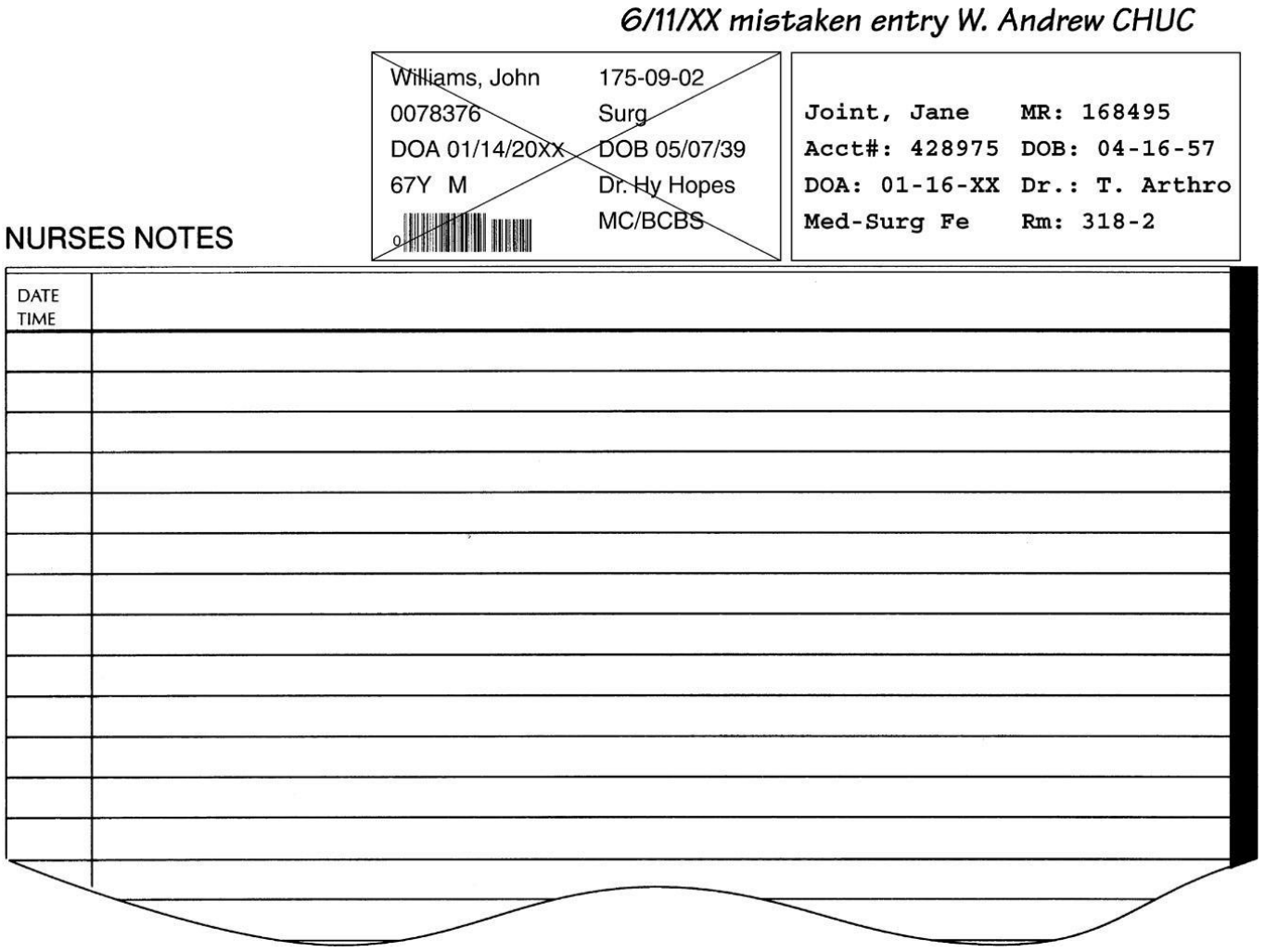
Methods of Error Correction on Paper Chart Forms

- Because the patient's chart is considered a legal document, information recorded on a chart form must not be erased or obliterated:
  - By pen
  - By covering with a label
  - By using liquid correction fluid
- If a chart form has notations on it, the chart form cannot be shredded.

Correction of ID Label

- Draw an X with a black ink pen through the incorrect label.
- Write “mistaken entry” with the date, time, and first initial, last name, and status (of the person correcting labeling error) above the incorrect label.
- Affix the correct patient ID label on the form next to the incorrect label.
  - Do not place the correct label over the incorrect label.
  - It is also permissible to hand print the patient information in black ink next to the incorrect label that has an X drawn through it.

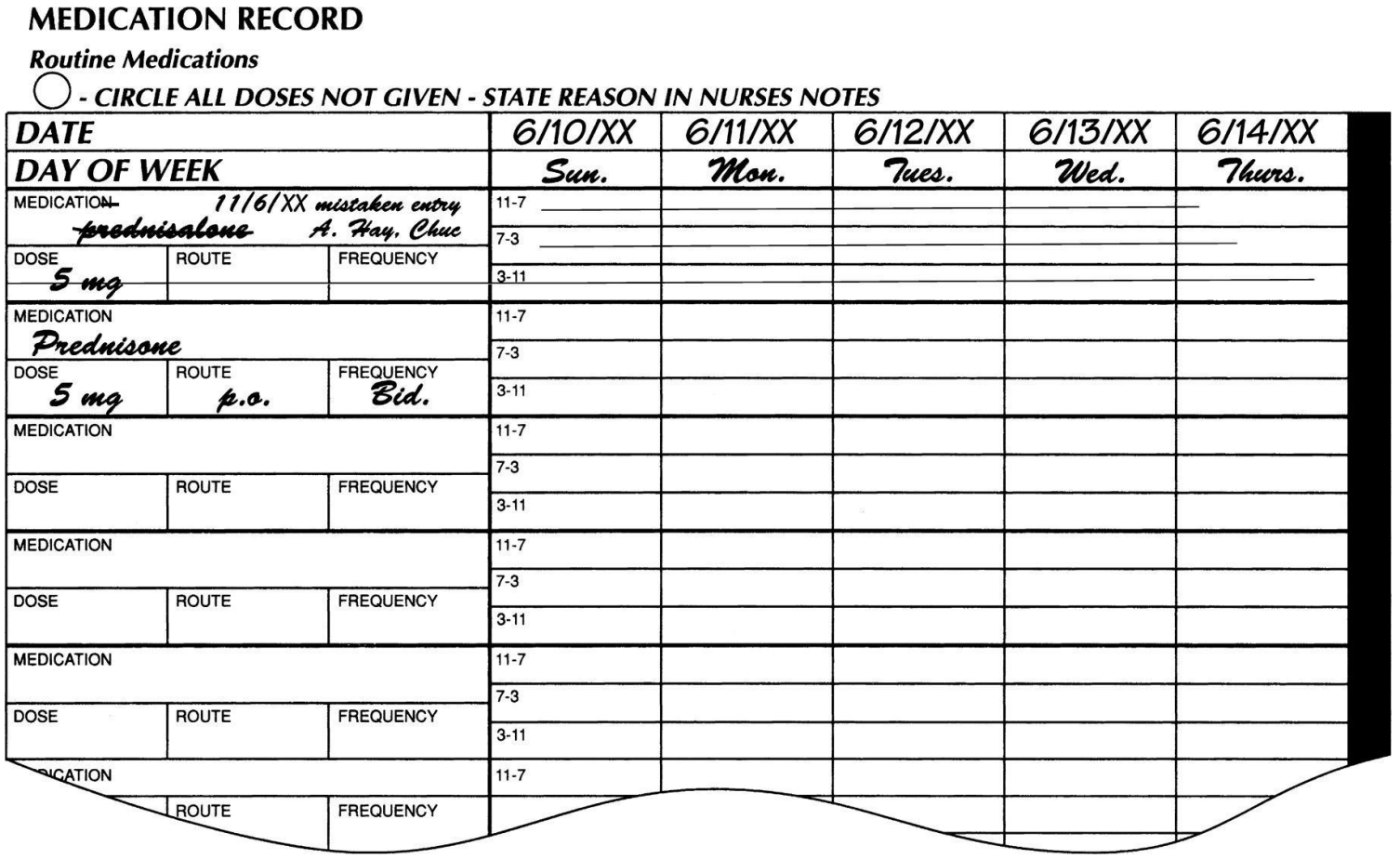
Correcting a Labeling Error



Correction of a Written Entry

- Draw (in black ink) one single line through the error.
- Record the words “mistaken entry” or “error.”
- Record the date, time, and your first initial, last name.
- Record your status (the status of the person correcting the error) in a blank area near the error (directly above or next to the error).

Correcting a Written Error



MEDICATION RECORD

Routine Medications

◯ - *CIRCLE ALL DOSES NOT GIVEN - STATE REASON IN NURSES NOTES*

DATE			6/10/XX	6/11/XX	6/12/XX	6/13/XX	6/14/XX
DAY OF WEEK			Sun.	Mon.	Tues.	Wed.	Thurs.
MEDICATION ~~prednisalone~~ 11/6/XX mistaken entry A. Hay, Chuc			11-7				
			7-3				
DOSE ~~5 mg~~	ROUTE	FREQUENCY	3-11				
MEDICATION Prednisone			11-7				
			7-3				
DOSE 5 mg	ROUTE p.o.	FREQUENCY Bid.	3-11				
MEDICATION			11-7				
			7-3				
DOSE	ROUTE	FREQUENCY	3-11				
MEDICATION			11-7				
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DOSE	ROUTE	FREQUENCY	3-11				
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ICATION			11-7				
	ROUTE	FREQUENCY					

Monitoring and Maintaining the Patient's EMR

- HUC Duties:
  - Monitor patient’s EMR consistently.
  - Complete HUC tasks as required and in a timely manner.
  - Assist nurses, doctors, and ancillary personnel as necessary in entering information and orders into the computer.
  - Report any necessary repairs regarding nursing unit computers and/or printers to the hospital information systems department.

Monitoring and Maintaining the Patient's EMR, cont'd

- HUC Duties (cont'd):
  - Scan documents as required in a timely manner.
  - Place and maintain patient ID labels in a patient label book.
  - Place patient face sheets into the face sheet binder, which may be the same as the label book, to provide to physicians as requested.
  - Always log out of the EMR when not in use to protect patient confidentiality.

Maintaining the Patient's Paper Chart

- HUC Duties:
  - Place all charts in proper sequence in chart rack when not in use.
  - Place new chart forms (labeled with patient ID label) in each patient’s chart before immediate need arises.
  - Place diagnostic reports in correct patient’s chart behind correct divider.
  - Review patients' charts frequently for new orders.
    - Always check each chart for new orders before returning them to chart rack.

Maintaining the Patient's Paper Chart, cont'd

- HUC Duties (cont'd):
  - Properly label the patient’s chart so it can easily be located at all times.
  - Check each chart to be sure that all forms are labeled with the correct patient’s name.
  - Check the chart frequently for patient information forms or face sheets.
  - Assist physicians or other professionals in locating the patient’s chart.

Splitting or Thinning the Paper Chart

- The paper chart of a patient who remains in the health care facility for a long time becomes very full and eventually becomes unmanageable.
- The HUC may “thin” or “split” the chart.
  - A doctor’s order is not required to thin a patient’s chart.
- In thinning the chart, some categories of chart forms may be removed and placed in an envelope for safekeeping on the unit.

Guidelines for Thinning a Patient's Chart

- Remove older nurse’s notes, medication forms, and other forms that are no longer needed in the chart binder.
- Place the removed forms in an envelope.
- Place the patient’s ID label on the outside of the envelope.
- Write “thinned chart” and record the date with your first initial and last name on the outside of the envelope.

Guidelines for Thinning a Patient's Chart, cont'd

- Place a label stating that the chart was thinned.
- If the patient is transferred to another unit, transfer the thinned-out forms with the patient’s chart.
- When the patient is discharged, send all thinned-out forms with the patient’s paper chart to the health information management department.

Reproduction of Chart Forms that Contain Patient Information

- EMR:
  - Available on computer to other health care facilities, or the records may be printed from the computer
  - The patient will be required to sign a release form for the records to be available or copied in this situation.
- Paper charts:
  - Records will need to be reproduced using a copy machine.

Reproduction of Chart Forms that Contain Patient Information, cont'd

- The patient’s doctor must write an order specifying the specific chart forms to be copied, and the patient will be required to sign a release form.
- Depending on hospital policy, the HUC may have the responsibility of copying the paper chart forms, or the patient’s chart may be sent to the health information management services to be copied.
- After the forms are reproduced on the copier, the original forms are replaced in the patient’s chart, and the copied records are sent to the receiving facility.