

**ECU Physicians Administration  
Policy and Procedure Manual**

Topic: Medical Record Completion and Unsigned Documents - # IM 12	
Section: 6	Section Name: Information Management
Approval Date: 07/06/99; rev. 12/08/11	Approval: Paul. R.G. Cunningham, MD, FACS

**I. Purpose:**

The purpose of this policy is to provide guidance to health care providers in meeting their obligations to review and complete the documentation of care process. Entries in the medical record will be made to reflect each patient event of care provided within this organization. These entries shall be characterized by generally accepted documentation features, including their timely authentication by the responsible provider(s). Compliance: monitoring for adherence will be accomplished by Health Information Systems and Services (HIS/S) with routine annual oversight by the Office of Compliance as a part of standard monitoring systems' review procedures.

**II. Definitions:**

Authentication – The act of taking responsibility for a document by affixing an electronic signature that includes credentials and date. For paper records and scanned documents, this signature will be handwritten.

Document – Any handwritten, dictated/typed, electronically produced or returned patient care documentation, and/or outcomes of ordered ancillary services resulting from an event of care involving a patient of the ECU Physicians ambulatory environment.

Patient event of care – all instances of direct interaction with a patient or their representative. This includes, but is not limited to, patient clinic visits, telephone or electronic interactions, hospital-based interactions, receipt of diagnostic testing reports, and receipt of reports on patient evaluations or treatments by external agencies.

**III. Policy:**

For reporting and compliance purposes, it is the policy of ECU Physicians that all documentation generated from a patient event of care that is not completed and authenticated by all responsible provider(s) within five (5) working days from the actual event will be addressed as follows:

- A. A summary report indicating number of unsigned documents by a provider, greater than five (5) working days old, will be generated by HIS/S and provided to Department Chairs monthly.
- B. A summary report indicating number of individual unsigned documents, greater than five (5) working days, will be generated by HIS/S and provided to the responsible provider monthly. A senior administrator within the department (CADA, CAM, or similar) will directly contact the provider to emphasize the need

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ECU Physicians Board of Directors		
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to complete the charts. After three daily attempts by the senior departmental administrative staff to resolve the notation/signature delinquencies with the provider have failed to resolve the delinquencies, the Medical Director of ECU Physicians and the Department Chair will be notified of the outstanding delinquency. The Chair will then be responsible for contacting the individual who has unsigned office visits greater than ten (10) working days old. The Chair will be responsible for generating a formal letter to the individual at ten (10) working days, which should remind the individual of the outstanding records and refer to sanctions which could be invoked in the event charts are still delinquent when they are 20 working days old. After 20 working days of lack of corrective action, a Warning Letter will be sent by the Chair to the responsible provider. A copy of the letter will also be sent to the Medical Director.

1. Reasonable allowance will be made for a provider who is on vacation or otherwise unable to complete the documents.

C. The Sanctioning Process can involve the following:

1. The Chair may appropriately reduce the supplemental portion of that faculty's salary in a manner consistent with applicable policies.
2. The Chair will inform the provider in writing that failure to complete the deficiencies in a specific time period may lead to:
  - a. No approval of vacation time, bonus vacation time, continuing medical education (CME) time, as well as the availability and future use of discretionary funds, as long as the medical record delinquencies exist.
  - b. Previously scheduled, but not yet used, vacation time, CME time, and previously approved use of discretionary funds by ECU employees may be revoked as long as the delinquencies exist.
  - c. Violations of this policy will be part of the consideration when the Chair makes recommendations about allocating faculty productivity and retention payments.
  - d. For resident physicians, discretionary funds may be withheld, whether these funds are managed by the department or by the Office of GME. Further, the resident physician may be pulled off clinical duties to complete their records. In selected cases,

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suspension may be indicated. The policies and procedures of the PCMH Office of GME will be followed.

3. The Chair will document performance deficiencies in the faculty member's annual evaluation.
  4. When the faculty member resolves all documentation deficiencies, any actions outlined in paragraph C.2. above will be lifted. However, if the Chair is notified more than two times in a period of 365 consecutive days about documentation deficiencies for a specific faculty member, the Chair may employ any of the sanctions outlined in paragraph C.2. above even after all deficiencies are resolved.
  5. The Medical Director, the Executive Director or the Dean may contact the Chair at any time to discuss sanctions they feel are appropriate when a provider demonstrates an ongoing or recurring inability to complete their records according to the requirements of this policy.
  6. Under the North Carolina Practice of Medicine General Statute 90-14(6); a complaint may be written to the North Carolina Medical Board and the ECU Physicians/PCMH Credentialing committees describing non-compliance with applicable policies.
  7. The Medical Director of ECU Physicians may suspend clinical privileges should the failure to complete medical records have a negative impact on patient care. The Medical Director of ECU Physicians will work in collaboration with the Office of Compliance, Office of Risk Management and the University Attorney to implement this process should it become necessary, using the guidelines documented in the ECU Physicians Credentialing Plan.
  8. Sample letters in the suggested format are shown as Attachment #1 to this policy.
- D. It is the responsibility of the attending physician in the role of supervising the work of resident physicians, medical students, physician's assistants, nurse practitioners, and other providers to assure the chart is completed on a timely basis per this policy and to assure that the information in the chart is a complete and accurate recording of the relevant aspects of the event of care.

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**IV. Procedure**

- A. Paper Medical Record – Documents are either generated immediately (e.g., handwritten progress note, phone note) or via external clinic resources and returned to the responsible provider(s) (e.g., transcribed progress note, lab report, x-ray report).
1. Documents generated immediately are to be authenticated by the responsible provider(s) at the conclusion of the event of care. The completed documents are then to be forwarded to HIS/S for filing in the official medical record.
  2. Documents generated using external clinic resources will be returned to the responsible provider for review and authentication. If applicable, countersignature will be coordinated according to clinic operational guidance. The completed documents are then to be forwarded to Medical Records for filing in the official medical record.
- B. Electronic Medical Record –
1. For the Centricity EMR, documents appear on the responsible provider’s desktop indicating patient’s name, date of encounter, document summary, and status. To view a listing of pending document actions, providers should access their individual desktop using their log-on and password. Documents needing authentication will have the status identified as “signature”. The provider should review, edit document as appropriate and click “Sign”. This affixes an electronic signature that includes name, credentials, date, and time and makes the document a permanent part of the record.
  2. In the HealthSpan Ambulatory EMR, providers need to monitor their individual in-basket for any open charts (clinic visits) or open encounters (telephone, nurse only, orders only, or refill encounters). Closing these encounters affixes an electronic signature to the documentation.
- C. Departing Providers -
1. Providers leaving ECU Physicians should follow guidelines for completing medical records provided in the Departing Providers Policy.

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1. HIS/S in conjunction with the Departmental Chair, Director of Risk Management, Chief Compliance Officer, and Director of Clinical Financial Services will resolve any unsigned documents remaining after physician departure.
  2. When a Provider has departed from ECU Physicians for more than a month with a significant number of unsigned or incomplete documents, the Medical Director may inform the North Carolina Medical Board of the provider's failure to adhere to applicable policies. The provider will be reminded of the need to complete charts and the potential for informing the Medical Board at least two weeks prior to any communication with the Board. The provider will receive a copy of any written communication with the Board.
2. Monthly unsigned document reports for resident physicians will be forwarded to program directors prior to graduation and should be used to secure resident physician signing. The program director may withhold the graduation certificate until records are completed. The policies and procedures of the PCMH Office of GME will be followed.
1. Any unsigned documents remaining after a resident physician's graduation will be forwarded to the Attending Physician for completion.  
<http://www.facebook.com/media/set/?set=a.237312476337547.51379.135295353205927&type=1>

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