Edward-Elmhurst HEALTH | Healthy Driven

Elmhurst Memorial Hospital

DICTATING INSTRUCTIONS

Dial in-house: **Ext. 1-5510** Outside: 331-221-5510

1. Enter your 4-**digit Physician Number** followed by the # key. NOTE: a valid 4-digit ID must be entered.
2. Enter the **Work Type Number** followed by the # key. - NOTE: a valid Work Type number must be entered.

02-Consultation Report	**06-Operative Report**	**10-Pain Clinic**
03-Discharge Summary	**08-Sleep Study**	**26-Interventional Radiology**
04-History and Physical	**09-EMG/EEG**	**27-Invasive Cardiology**

4. Enter the **EPIC CSN number** followed by the # key.
5. Press **2** and begin dictating after the prompt.
6. Press **8** to dictate multiple reports and/or to disconnect from the session, press **5.**

SPECIAL FEATURES - PRESS:	
2	Dictate/Pause (toggle switch)
3	Short Rewind and automatic Playback
44	Forward to end of Report
5	Disconnect
77	Rewind to beginning of report
8	End report when dictating more than one report.
6	**Gives Job ID Number**

Elmhurst Memorial Hospital

Assistance Numbers: External-331-221-5628

In-House-1-5628

Physician ID Assistance:

External-331-221-4357

In-House-1-4357

DIGITAL TRANSCRIPTION SYSTEMS INC.

HELP DESK 855-493-7382 Ext 0

Work Type	Description
2	Consult
3	Discharge Summary
4	History and Physical
6	Operative Report
8	Sleep Study Report
9	EEG Report
10	Pain Clinic – Procedure Note
15	EMG Report
21	Cancer Center Progress Note
22	Cancer Center – Consultation
23	Cancer Center – New Patient Consultation
26	Interventional Radiology
27	Cardiac Procedure Transcription
90	RAD/ONC – Consultation
91	RAD/ONC – Treatment Summary
92	RAD/ONC – Follow-up Note

Edward-Elmhurst HEALTH | Healthy Driven

Elmhurst Memorial Hospital

Department of Medicine Warning and Suspension Procedure

PURPOSE: This policy lists the required components of a medical record that will be used for delinquent record completion and the process for warning and suspension.

DEFINITION: A delinquent medical record is an inpatient, observation, ambulatory surgery, endoscopy, cardiac cath, and OR records which is missing the following documents:

1. H&P (All Areas)
2. Discharge Summary (Inpatient and Observation)
3. Operative and Procedural Report
4. Signatures
5. Other missing items

SUSPENSION PROCEDURE

A. WARNING PROCESS

1. A physician with missing documentation more than 14 days will receive a warning notification. A warning notice of incomplete medical records will be sent to the providers In Basket in EPIC or faxed based on their preference. Subsequent 2nd and 3rd notifications will be sent 21 days and 28 days respectively if such records are still not complete.

B. SUSPENSION PROCESS

1. Missing documentation 30 days past the discharge date will be marked as delinquent and will qualify a physician for suspension. Medical Records will notify the physician's office with a phone call on Monday's prior to being suspended on Thursday the following week. A physician will be placed on suspension if they do not complete delinquent charts after receiving a warning letter and a phone call the previous week.
2. Physician's planning vacation time need to notify Medical Staff Office. Physician's returning from vacation are allowed 7 days to complete their work before being suspended. Physicians who are already suspended before taking vacation remain suspended until charts are complete.

C. SUSPENSION OF PRIVILEGES

1. All Medical Staff Rules and Regulations regarding suspension of admitting privileges for delinquency apply.

D. CONTINUED SUSPENSIONS

1. A physician who remains suspended will receive a suspension notification every 7 days that they are still on suspension.
2. Internal Medicine department suspension notification will include the number of weeks that physician has been on suspension.

E. COMPELETION OF DELIQUENT MEDICAL RECORDS

1. Once a physician has completed all of their delinquent medical records, the physician will be removed from suspension. The suspension list will be updated and distributed to reflect the removal of the physician from suspension.

F. FINES

1. A fine of $50.00 per week will be assessed for any physician who remains on the suspension list for delinquent medical records for eight (8) consecutive weeks with the fine being assessed beginning on week nine (9).
2. A fine of $50.00 per week will also be assessed for any physician who in on the suspension list for twelve (12) or more non-consecutive weeks during a rolling 12 month period with the fine being assessed beginning on week thirteen (13).
3. The fine will be assessed regardless of the number of delinquent medical records.
4. The physician will be notified monthly of the total delinquent fee owed. The fee is due upon receipt of the invoice.

G. REAPPOINTMENT

1. If the physician has not paid all delinquent fines by the time of reappointment, then the physician is considered resigned from the Medical Staff.

H. APPEAL PROCESS

1. If at any time a physician believes that a suspension has been issued in error, the physician should notify the Chairman, Department of Medicine and the Vice President, Medical Affairs in writing of the error within 30 days of the suspension. The physician should include the medical record(s) in question and details of the error. The Chairman, Department of Medicine and the Vice President, Medical Affairs will review the appeal and make a determination.
2. If the suspension was issued in error, all Medical Staff records will be corrected and fines issued in error will be refunded.

Edward-Elmhurst HEALTH | Healthy Driven

Elmhurst Memorial Hospital

Medical Staff Rules and Regulations

The following contains an excerpt from the Medical Staff Rules and Regulations pertaining to Record Completion.

1. **Orders**

   Section C, Paragraph 1-6, 17

2. **Record Completion**

   Section C, Paragraph 18

3. **History and Physical**

   Section B, Paragraph 1-5

4. **Progress Notes**

   Section B, Paragraph 5

5. **Operative Report**

   Section B, Paragraph 6

6. **Consultation**

   Section B, Paragraph 7

7. **Discharge Summary**

   Section B, Paragraph 12

B. Medical Records

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data; complaint, personal history; family history; history of present illness; physical examination; speech reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge note and discharge summary; and autopsy report when performed.

   All physicians will abide by Public Act 78-292 relative to uterine cytological examination (Pap smear). Compliance will be recorded in the hospital chart.

2. A complete admission history and physical examination shall be recorded within twenty-four of inpatient hospital admission. A complete history and physical should contain: presenting complaint, history of present illness, past medical and surgical history, current medications, family history, social history, review of systems, physical exam including major and pertinent body systems and organs, diagnostic impression, proposed plan of treatment. If a complete history has been recorded and a physical examination within 30 days prior to the patients admission to the hospital, a reasonable durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of physical examination, provided these reports were recorded by a physician or other qualified licensed individual in accordance with state law and hospital policy. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded. When the period of hospitalization has been 48 hours or less, and when a major surgical procedure has not been (except in case of a death), the medical record may be abbreviated to include only the following diagnosis (admitting and final), present illness, purpose of admission, appropriate items in the past history, and reginal or appropriate examination, treatment and final summation.

   When the period of hospitalization has been 48 hours or less, when there has been no major surgical procedure, and when the patient is discharged alive, the medical record may be abbreviated to include only:

   A. Admitting Diagnosis
   B. Purpose of Admitting
   C. Relevant Past History
   D. System Focused Present History
   E. System Focused Physical Exam
   F. Discharge Diagnosis

3. Test results derived pre-hospitalization may be included in the Medical Record if they are relevant to the current admission. Such "test results" for purposes of this paragraph shall be limited to laboratory results derived in a laboratory licensed by the State of Illinois, EKG tracings, and x-ray reports as interpreted by a radiologist.

Entry of these results into the Medical Record shall in no way abrogate existing departmental or medical staff regulations which require a certain test(s) to be performed or repeated on admission, including but not limited to prenatal testing. Results for inclusion in the Medical Record must be hand-delivered by the practitioner to the nursing until where the patient is admitted within 24 hours of admission.

Entry of these results in the Medical Record does not relieve the practitioner of the duty to provide a complete history and physical examination as set forth elsewhere in these "Rules of Regulations".

4. The attending physician shall countersign the history, physical examination, pre-operative note and discharge summary when they have been recorded by a member of the house staff, a medical student, a nurse, or by other authorized paramedical personnel.

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. These progress notes will be dated, times and authenticated. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders such as results of tests and treatment. Progress notes shall be written daily on all patients with the exception of patients admitted to the Psychiatric Unit, on who progress notes must be written five out of every seven days, but in no event shall a physician fail to document his assessment of the patient for a period greater than two days.

    A. All procedure that are done in the OR, cath lab or endoscopy require a History and Physical and these H&Ps need to be less than thirty (30) days old and require an update note added immediately prior to the procedure (the note may simply reflect that the patient states that there has been no interval change).

    B. Interventional Radiology procedures:

        1) Image guided biopsies of the lung; liver and kidney require a private physician completed brief H&P form or same information in an office progress note. This exam must be less than thirty (30) days old.

            This information is reviewed with clinical staff and signed off by the radiologist.

        2) All other ambulatory procedures performed in interventional radiology that place the patient at some risk require a brief note that includes:

            a. Reason for the procedure
            b. Significant past medical history
            c. Current medications
            d. Allergies
            e. Plan for anesthesia
            f. Vital signs
            g. Examination of heart and lung and body part/system to be evaluated or treated

            This information may be obtained by clinical staff in the procedural area, but must be reviewed and co-signed by the procedural physician prior to the procedure.

C. All outpatients procedures that do not require sedation and do not place the patient at significant risk (PICC lines, cast applications, bone marrow aspirations, thoracentesis, paracentesis, arthrocentesis, myelogram, lumbar puncture, cyst aspiration, fine needle aspiration of thyroid, fine needle aspiration of breast, mammotone) do not need a History & Physical, but simply a brief past medical history, allergy list, current med list, diagnosis and reason for treatment/procedure.
This information may be obtained by clinical staff in the procedural area, but must be reviewed and co-signed by the procedural physician prior to the procedure.

6. All inpatient and outpatient procedure that are performed in interventional areas (operating room, endoscopy, cath lab, interventional radiology and radiology guided procedures: lung biopsy, liver biopsy, kidney biopsy, radio frequency ablation) require an immediate post procedure note that contains all seven elements.

    A. Procedural physician and assistant
    B. Name of operative procedure
    C. Description of operative procedure
    D. Operative procedure findings
    E. Specimens removed
    F. Post-operative diagnosis
    G. Estimated blood loss

    Complete dictation about the procedure must be completes within 24 hours of procedure.

7. The following inpatient procedures require a post procedure note:
    A. All bedside procedures
        1. Thoracentesis
        2. Pleural biopsy
        3. Paracentesis
        4. Bone marrow aspiration
        5. Would debridement
        6. Spinal tap
    B. Access line (central venous and arterial)
    C. Thoracentesis, paracentesis, and arthrocentesis
    D. Cast applications outside the OR
    E. All procedures performed in the ED

12. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated, timed and authenticated by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order. No patient will be discharged without a discharge order.

C. GENERAL CONDUCT OF CARE

1. A general consent form signed by or on behalf of every patient admitted to the hospital must be obtained at the time if admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

2. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a registered professional nurse, to a registered respiratory therapist or respiratory care technician, to a registered dietitian, or to a registered therapist in the Rehabilitation Department, including certified speech pathologist.

3. All orders given to a respiratory therapist or respiratory care technician must be strictly limited to respiratory procedures only. All orders given to a dietitian shall be strictly limited to nutritional care only. All orders given to a rehabilitative therapist shall be strictly limited to rehabilitation services only. All verbal orders shall be signed by the registered nurse, registered respiratory therapist or respiratory care technician, registered dietitian or registered rehabilitative therapist to whom dictated with the name of the dictating practitioner above his or her own name.
   A responsible practitioner shall authenticate all therapeutic orders within thirty-days. In the course of their practice, the registered pharmacists may encounter dilemmas, which prevent the dispensing of medication on specific patient orders. The pharmacist is responsible for resolving these dilemmas with the prescriber. Therefore, the pharmacist, after consultation with the prescriber, may accept new medication orders as well as cancellations or changes to existing medication orders. The registered pharmacist will enter these orders into the patient's medical record on the medication and treatment order sheet. The pharmacist will sign his or her name to the order and record the date and time. The pharmacist will also notify the nurse responsible for this patient of the existence of these orders. The nurse will have the authority to act on these orders.

4. The practitioner's orders must be written clearly, legibly, and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse. The use of "Renew," "Repeat" and "continue orders" are not acceptable.

5. All drugs and medications administered to patients shall be those listed on the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.
   A patient may take no drugs brought into the hospital unless authorized by written order of the attending physician.

   All narcotics and analgesics shall be discontinued after 72 hours, unless

   A. The order indicated an exact number of doses to be given; and
   B. The exact period of time (not just until discontinued) is specified; and
   C. The attending physicians or his representative rewrites the order, changes the order or cancels it.

6. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise.

EDWARD
HOSPITAL & HEALTH SERVICES

GENERAL DICTATING INSTRUCTIONS

Dial inhouse: **Ext. 75050** Outside: 527-5050
(New 800 number= 844-277-7693)

1. Enter your **5-digit Physician Number** followed by the # key. *NOTE: a valid 5-digit ID must be entered.*
2. At the Facility ID prompt, please enter the **Facility ID Number = 02** followed by the # key
3. Enter the **Work Type Number** followed by the # key. *NOTE: a valid Work Type number must be entered.*

1-History and Physical 3-Operative Report 10-Cardiodiagnostics
2-Consultation Report 4-Discharge Summary 15-Sleep Center Reports
94-Delivery Note (C-section use #3) 500-Cardiac Procedure Transcription

4. Enter the **EPIC CSN number** followed by the # key.
5. Press **2** and begin dictating after the prompt.
6. Press **8** to dictate multiple reports and/or to disconnect from the session, press 5.

SPECIAL FEATURES - PRESS:

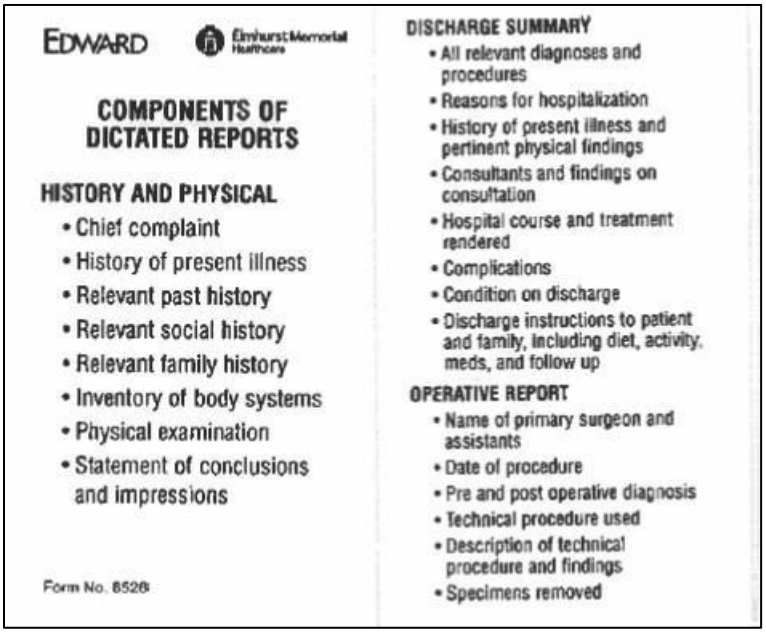
2 Dictate/Pause (toggle switch)
3 Short Rewind and automatic Playback
44 Forward to end of Report
5 Disconnect
77 Rewind to beginning of report
8 End report when dictating more than one report.
6 Gives Job ID Number

EDWARD HOSPITAL ASSISTANCE NUMBERS:
External-630-527-5055 In-House-75055

PHYSICIAN ID ASSISTANCE:
External-630-527-3346 In-House-73346

Digital Transcription Systems, Inc.
HELP DESK - 405-948-9200 X155

Form No. 81007 (Rev 12/15)



EDWARD Elmhurst Memorial Healthcare

COMPONENTS OF DICTATED REPORTS

HISTORY AND PHYSICAL

- Chief complaint
- History of present illness
- Relevant past history
- Relevant social history
- Relevant family history
- Inventory of body systems
- Physical examination
- Statement of conclusions and impressions

Form No. 8528

DISCHARGE SUMMARY

- All relevant diagnoses and procedures
- Reasons for hospitalization
- History of present illness and pertinent physical findings
- Consultants and findings on consultation
- Hospital course and treatment rendered
- Complications
- Condition on discharge
- Discharge instructions to patient and family, including diet, activity, meds, and follow up

OPERATIVE REPORT

- Name of primary surgeon and assistants
- Date of procedure
- Pre and post operative diagnosis
- Technical procedure used
- Description of technical procedure and findings
- Specimens removed

If you would like a physical dictation card, please email Hiren.Dhimar@EEHealth.org and one will be mailed to you.