Medical Record Documentation and Abbreviations Policy Guidelines

Local health departments should have a policy on medical records documentation. The policy should be reviewed, updated as needed, and signed at least annually within your agency. Agency staff should have access to this policy and should follow it when documenting in the medical record.

At a minimum, the following should be included in your agency **Medical Record Documentation** policy:

1. A definition of who may document in the record.
    - Requirements for signatures in the medical record.
        - The minimum is 1st initial, last name & credentials. Your agency may choose more stringent requirements.
        - If initials are used (such as for flow sheets, etc.), there needs to be a corresponding full identification either on the same form or on a signature legend. Initials should not be used on narrative notes or assessments, or anywhere else a signature is required by law.
2. Timely signing of the medical record.
    - Every entry should include a complete date: month, day, year & time. Entries should be made as soon as possible after an event or observation is made. Your policy may define an acceptable time frame for signing/ "completing" the record.
    - The policy should include how late entries are handled: how they are annotated (i.e., an addendum).
3. Process for scanning paper documents, reports, letters, etc. into the medical record.
4. If documents are completed in multiple sections by different healthcare providers (for example, if a nurse completes vitals and interviews the patient before the patient is seen by the physician or advanced practice provider), the documentation policy should outline how to document, making it clear to the reader who completed each section.
    - The documentation policy should outline the process to determine who completed information in each section.
    - Each provider must sign for the care, assessment, data collection they completed.
    - Authors must always make and sign their own entries in the medical record.
5. Agencies (providers) should perform periodic audits of electronic health records, using a standard tool. OCPHN provides a copy of its record review tool, and it is available on the For Local Health Departments webpage. Determine how many records to be reviewed for a designated time frame. A multidisciplinary team that understands documentation, coding and billing principles is recommended to conduct agency audits. Evaluate audit findings, looking for any trends. Once findings are evaluated, develop a corrective action plan and implement it to correct problem(s) and improve compliance. Educate staff and perform a follow-up audit to ensure improved processes or outcomes.
6. All EHR users should be aware of and utilize the security features of their EHR system. Agency policy should include all required security practices for EHR users. For example, encryption of data, password protection, and precautions to be taken when using mobile devices. Agencies may develop a specific policy with agency-wide security and privacy guidelines and requirements for protected health information.

7. For further guidance in developing or revising policies and procedures please refer to our For Local

Health Departments webpage. We have an outline of what components are recommended for a well-written policy, as well as a Policy and Procedure Template. Using the template is NOT required but may be helpful. It is recommended, however, that all your agency policies and procedures are in the same format for ease of use. Please reach out to your OCPHN Nurse Consultant for further guidance as well.

Abbreviation Requirements:

1. If your medical records documentation policy does not include abbreviations, your agency should have a separate approved abbreviations policy or list.
2. Only abbreviations that are on the official policy/ approved list should be used.
3. When there is more than one meaning for an abbreviation, the policy/ list should define which will be used.
4. Include abbreviations specific to your agency/ community. For example, the abbreviated name of your agency or any community partners you often use (local hospitals, community resources, etc.)

Additional information on documentation standards can be found in the resources linked below:

1. 21 NCAC 36.0224 Components of Nursing Practice for the Registered Nurse: http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0224.pdf

2. CMS Complying with Medicare Signature Requirements (4/2024): https://www.cms.gov/files/document/mln905364-complying-medicare-signature-requirements.pdf

3. CMS Documentation Matters Toolkit (9/10/2024): https://www.cms.gov/medicare/medicaid-coordination/states/dcoumentation-matters-toolkit

4. CMS Medicaid Documentation for Medical Office Staff (12/2015): https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/docmatters-officestaff-factsheet.pdf

5. CMS Medicaid Documentation for Medical Professionals (12/2015): https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/docmatters-medicalprof-factsheet.pdf

6. NCBON History and Physical Examination, Position Statement for RN Practice (9/2022): https://www.ncbon.com/sites/default/files/documents/2024-03/ps-history-and-physical-examination.pdf

7. NC DHHS Policy and Procedure Development (1/2023): www.dph.ncdhhs.gov/media/733/download?attachment

8. NC Medical Board Position Statement- Medical Records – Documentation, Electronic Health Records, Access, Retention (11/2024): https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/medical-records-documentation-electronic-health-records-access-and-retentio

9. Nurse.org How to List Your Nursing Credentials (6/11/2024): https://nurse.org/articles/displaying-your-nursing-credentials/#why-how-you-list-your-nursing-credentials-matters

10. Palmetto GBA- Jurisdiction M- Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices (2/13/2024)
11. https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/8EEM4Q2610~Comprehensive%20Error%20Rate%20Testing%20(CERT)~Documentation

12. The Joint Commission FAQs (2/8/2022): https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/information-management-im/000001457/

13. The Joint Commission Official "Do Not Use" List (9/14/2018): https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/patient-safety/do_not_use_list_9_14_18.pdf