Medical Records

House Staff Orientation

Located Basement of Rock
Financial Counseling & Medical Records

Hours of operation
7 days a week
2 shifts – 7:30 a.m. through 11 p.m.

Main phone number – 2-2044
Key Interactions with MRD

- Record Access – Imaged medical record
  - Record Completion – on-line
    ✓ Discharge Summary Dictation
    ✓ Operative Report Dictation
- Death Certificates/Gift of Life/Autopsy consent
- Documentation
Imaged Medical Record

Over > 100 COLD feeds from the ancillary systems

All health system hospital encounters from 2004 to present

Cross encounter information consistency

(3) days Hot Feeds

Pick-up IMR tracking Prep Scanning

Chart Deficiency module with report editing & e-signature

Coding Clarification Processing & E-forms

Physician office dictated notes
Main Alpha IMR patient

• Search Screen

Welcome to Temple University Health System's imaged medical record. Our imaged record is maintained in the regular course of business, and is certified as an exact replication of the original documents generated in the normal course of business.

In order to maintain the quality and integrity of our record, built into the system is an electronic image quality-reporting tool. We ask all users to report any quality issues through this tool. The tool can be accessed through the Page Navigation Section tool bar when viewing the record.

Search by Name, (all records)

MRN (TUH & JNS)

All Dictations (DISCH SUM & O.R.) Complete within 30 days of discharge

Suspension thresholds Attendings are eligible for suspension of

7 records > 10 days
1 record > 30 days

Operative Reports - dictate immediately

Residents are eligible for suspension of undictated operative reports greater than 7 days
A Penrose drain was then used to control the hernia and cord structures. With this accomplished, the hernia was then reflected anteroinferiorly. Cord structures were dissected posterosuperiorly. A very large cord lipoma was then identified along the side of the cord. This was dissected along its full extent and removed and sent to Pathology. The hernia was then dissected fully to identify the hernia sac. A hernia sac was then ligated using 2-0 Vicryl suture and reduced. Dissection was then performed in the propertional space. The floor of the inguinal region was found to be completely weakened and the source of the direct inguinal hernia. This area was then thoroughly irrigated. A large Ethicon hernia system was then used. It was closed within the weakened floor to secure the floor. Vicryl 0-0 suture was used to suture the hernia system to the fascia overlaying the pubic tubercle medially and to secure the medial extent of the repair. Fascial suture was then used to secure the mesh to the inguinal ligament inferriorly and to the conjoint tendon superiorly. The mesh was then excised of anterolateral extent and brought on to the cord with adequate laxity and did not cause any constriction of the cord. It was secured with a Prolene suture to reapproximate the tails of the mesh while securing it to the overlying tissue. The floor was then checked again and this was found to be an excellent secured repair in the gut and the laxity. Irrigation was then again performed with saline. The external oblique aponeurosis was reapproximated with 2-0 Vicryl sutures. Scarpas fascia was reapproximated with 2-0 Vicryl suture. Germini was reapproximated with 3-0 Vicryl suture, subcuticular layer was closed with 4-0 Monocryl. At the beginning of the case, a total of 10 mL were injected at the level of the ilioinguinal nerve and along the area of operation before a field block.

Benzin and Steri-Strips were applied to the incision. Dressings were applied. The patient was wakened from general anesthesia, extubated, and recovered to the PACU in stable condition.

ARUN K. MOHANTY, M.D.
DICTATED BY: Arun K. Mohanty, M.D.

DOD: 05/12/2011
DT: 05/13/2011
All physicians are given the features to modify the content of dictated reports.

Steps to Modify:

1. Press “Modify Document” button
2. Change report in popup window and press submit button
3. Sign document with requires signature button
Dictation System Access

• You need a personal dictation # to access the system
• After you complete computer training, you will be given your dictation system access

How to Dictate

Within hospital, dial 5555
Outside hospital, dial 1-877-292-5018
Follow prompts, enter your dictation #
Identify the work type:

1  Operative Report – TUH

2  Discharge Summary – TUH
Dictation TIPS

– Please start with:
  • patient name (spell it)
  • medical record #
  • admit & discharge date
  • include Attending by name

– At end of dictation a job # for dictation is provided – enter it into Alpha at the prompt
OPERATIVE REPORTS

• Are required for **EVERY** operative procedure performed.

• Inpatient and outpatient.

• An immediate post OP form to be filled out immediately following procedure.

• Full dictation also required through dictation system.
  – Immediately dictating after procedure recommended and preferred.
  – Required and should be done within 24 hours of completion of procedure.
Immediate Post Operative Note:

- An Immediate Post OP form must be completed immediately following procedures.
- This serve as a note while report is being transcribed.
- Must be dated and timed.
DISCHARGE SUMMARIES

• Required on **ALL** inpatient admissions
• LOS 4 days or under the MIS pathway can be used but all items must be completed.
  – Not acceptable if any item is listed as “pending”.
• LOS 5 days or greater will require a dictated Discharge Summary through the hospital dictation system.
  – Follow guidelines as set to include all necessary items (refer to dictation cards).
Dictated DC Summary - Good

Key Components

- Patient's name (Spell)
- Medical Record Number
- Admission/Discharge, Expiration Date
- Attending Physician
- History of Present Illness
- Hospital Course by Problem
- Disposition & Discharge Instructions
- Dictating Physician (Spell)
- Copies: Names (Spell) and Addresses

HISTORY OF PRESENT ILLNESS: Patient is an 07-year-old female with a past medical history of pulmonary artery disease status post PCI, carotid artery stenosis, arthritis, cataracts, sciatica, diverticulitis, dementia, GERD who presents with 1 day of bleeding from her urinary tract. The patient was discharged from rehab on Thursday prior to admission and the following day had decreased p.o. intake, lethargy, and altered mental status. Yesterday, the patient started to point of abdominal pain and blood clots in her urine. She denied any fever, chills, shortness of breath, cough, diarrhea. She was recently discharged from Temple for syncope vs hyp and was positive for carotid artery stenosis, though not intervened upon secondary to the patient’s wishes. Due the family, patient had UTI at the nursing home that was treated for 3 days with Augmentin and described the symptoms as dysuria and pain.

HOSPITAL COURSE BY PROBLEM LIST:
1. Urinary tract infection/sepsis. Urology was consulted and the patient was placed on continuous bladder irrigation. Her clots and hematuria eventually resolved. She was placed on a course of antibiotics, which was to be treated as an outpatient, and she was given a followup with Urology as an outpatient.
2. Coronary artery disease status post PCI. She had no issues during her stay and was maintained on a statin and aspirin. The Plavix was held secondary to her bleed. There was no beta-blocker as her pressures were on the lower side and patient was told to follow up as an outpatient to further evaluate and potentially for medication changes.
3. Hypothyroid. Patient was maintained on Synthroid and had no issues during her stay.
4. Dementia/ambulatory dysfunction. Geriatrics was consulted during her stay and the patient was to get home health per their recommendations.

DISPOSITION AND DISCHARGE INSTRUCTIONS: Patient was discharged home with medications as per the discharge instructions in fair condition and was given appropriate followup appointments.

Signed by: [Signature]
Date: 4/6/2013 3:17:51 AM

ATTENDING PHYSICIAN

DICTATED BY: [Signature]

Date: [Date]
Time: [Time]
Key Components

- Patient’s name (Spell)
- Medical Record Number
- Admission/Discharge, Expiration Date
- Attending Physician
- History of Present Illness
- Hospital Course by Problem
- Disposition & Discharge Instructions
- Dictating Physician (Spell)
- Copies: Names (Spell) and Addresses
DISCHARGE SUMMARY

SELECT DISCHARGE SUMMARY STATUS:

▷ I AM RESPONSIBLE FOR ENTERING THE DISCHARGE SUMMARY ON THIS PATIENT.

▷ DISCHARGE SUMMARY ON THIS PATIENT TO BE COMPLETED BY --DR. ---

▷ DISCHARGE SUMMARY WILL BE COMPLETED VIA MIS PATHWAY AS PATIENT'S LENGTH OF STAY LESS THAN OR EQUAL TO 4 DAYS.

▷ I WILL DICTATE A DISCHARGE SUMMARY, AS THIS PATIENT'S LENGTH OF STAY WAS GREATER THAN OR EQUAL TO 5 DAYS.
DISCHARGE SUMMARY

CHANGE DISCHARGE SUMMARY STATUS:

▷ I am responsible for entering the discharge summary on this patient.

▷ Discharge summary on this patient to be completed by --Dr. ___

▷ Discharge summary will be completed via MIS pathway as patient's length of stay less than or equal to 4 days.

▷ I will dictate a discharge summary, as this patient's length of stay was greater than or equal to 5 days.

EDIT SUMMARY

ERR
DIABETIC, TEST2
MD

NO UNSIGNED ORDERS

THIS PATIENT HAD NO UNSIGNED ORDERS

SELECT BELOW

› DISCHARGE INSTRUCTIONS & ORDERS.
› DISCHARGE SUMMARY.
› EXPIRATION ORDER.

RETURN ERR TYPE MASTER REVIEW RETRIEVE
MIS DC Summary - Good

03/27/13 12:42 AM

DISCHARGE INSTRUCTIONS & SUMMARY

PHYS: __________________________
ADM: 03/22/13

DISCH AGE: 43 Y

DISCHARGE SUMMARY
I AM RESPONSIBLE FOR ENTERING THE DISCHARGE SUMMARY ON THIS PATIENT
ENTERED BY: PRABHU NINA MD BTDA

CONDITION OF PATIENT ON DISCHARGE
GOOD

HISTORY OF PRESENT ILLNESS
REASON FOR HOSPITALIZATION:
--SHE WAS ADMITTED FOR INTRACTABLE NAUSEA AND EMESIS.

SIGNIFICANT FINDINGS & PHYSICAL EXAM:
--DRY MUCOUS MEMBRANES AND DECREASED WATERY OUTPUT FROM OSTOMY.
--HE WAS RECENTLY ADMITTED FOR NAUSEA/ABD PAIN AND DISCHARGED TOO EARLY
IN HER OPINION AS SHE HAD ONLY ONE REGULAR MEAL. WHEN SHE WENT HOME SHE
STARTED HAVING NAUSEA AGAIN AND NOT MUCH OUTPUT FROM HER OSTOMY BAG SO
SHE WENT TO THE HOSPITAL AGAIN.

HOSPITAL COURSE / RESPONSE TO TREATMENT
--SHE WAS STARTED ON IVF HYDRATION, IV ANTIEMETICS AND PAIN MEDS. SHE
WAS KEPT NPO UNTIL HER PAIN AND NAUSEA IMPROVED. HER DIET WAS SLOWLY
ADVANCED AND SHE WAS CLEARED FOR DISCHARGE AFTER BEING OBSERVED
TOLERATING A REGULAR DIET WITH GOOD OUTPUT IN HER OSTOMY BAG.

PROCEDURES AND TESTS PERFORMED DURING THIS HOSPITAL VISIT
PROCEDURE: NONE

TESTS: CT ABDOMEN PELVIS

LAST PAGE
MIS DC Summary - Bad

03/10/13  12:42 AM

DISCHARGE INSTRUCTIONS & SUMMARY

Phis:  [Redacted]  Age: 37 Yr  Adm: 03/05/13

DISCHARGE SUMMARY
I AM RESPONSIBLE FOR ENTERING THE DISCHARGE SUMMARY ON THIS PATIENT
ENTERED BY: FIBISON DIANA L MD  DLFA

CONDITION OF PATIENT ON DISCHARGE
GOOD

HISTORY OF PRESENT ILLNESS
REASON FOR HOSPITALIZATION:
PENDING
SIGNIFICANT FINDINGS & PHYSICAL EXAM:
PENDING

HOSPITAL COURSE / RESPONSE TO TREATMENT
PENDING

LAST PAGE

---
Completion of Death Certificate and related documents overview
Nursing Unit Instruction Packets

Patient Death Instruction Packets are on all nursing units
  ➢ Death Certificate blank and sample
    ➢ Most common errors
      ➢ Black ink, NO cross-outs, overwrites, name only on side, and cardiac arrest is not an acceptable cause of death!
  ➢ Gift of Life
    ➢ Regardless of age 100% of deaths are required to be called.
      ➢ This is a state requirement.
  ➢ Consent to Autopsy Form
    ➢ Most common error – must be signed by the physician
  ➢ Medical Examiner protocol
  ➢ MIS Pathway must be completed

Please note – the decedent cannot be released to the funeral director without the completed paperwork.
Documentation

Authentication is date/time/sign/beeper #

Write Legibly

Do Not use abbreviations

Verbal orders signed within 24 hours in MIS

Point of Care Scanning & Coding
### POC Coding Worksheet

**On admission**

<table>
<thead>
<tr>
<th>APR DRG</th>
<th>Description</th>
<th>MDC</th>
<th>Weight</th>
<th>Low Trim</th>
<th>High Trim</th>
<th>SOI</th>
<th>SOI-LOS</th>
<th>Coder ID</th>
<th>Coded Date</th>
<th>Final Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>194</td>
<td>HEART FAILURE</td>
<td>005</td>
<td>2.26</td>
<td>2</td>
<td>31</td>
<td>4</td>
<td></td>
<td>YANNONP</td>
<td>05/12/2010</td>
<td></td>
</tr>
<tr>
<td>DRG</td>
<td>Description</td>
<td>MDC</td>
<td>CMI</td>
<td>1.4609</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>291</td>
<td>HEART FAILURE &amp; SHOCK W MCC</td>
<td>005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**T-LOS**: 4.00

**Core Measure Chart:**

**Questions to Physicians**

**WORKING DRG - WAS SVT RELATED TO ACUTE DECOMPENSATED CHF OR PROGRESSION OF CHRONIC CHF ON ADMISSION?** If yes, please document.

<table>
<thead>
<tr>
<th>Seq POA</th>
<th>Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Y</td>
<td>Congestive heart failure, unspecified</td>
</tr>
<tr>
<td>2</td>
<td>N</td>
<td>Cardiogenic shock</td>
</tr>
<tr>
<td>3</td>
<td>N</td>
<td>Acute kidney failure with lesion of tubular necrosis</td>
</tr>
<tr>
<td>4</td>
<td>Y</td>
<td>Paroxysmal supraventricular tachycardia</td>
</tr>
<tr>
<td>5</td>
<td>Y</td>
<td>Primary cardiomyopathies</td>
</tr>
<tr>
<td>6</td>
<td>E</td>
<td>Status post automatic implantable cardiac defibrillator (AICD) in situ</td>
</tr>
<tr>
<td>7</td>
<td>Y</td>
<td>Pure hypercholesterolemia</td>
</tr>
<tr>
<td>8</td>
<td>Y</td>
<td>Essential hypertension, unspecified benign or malignant</td>
</tr>
</tbody>
</table>
Never Use the Following Abbreviations

- **QD** (daily)
- **QOD** (every other day)
- **U** (units)
- **IU** (International units)
- **MSO4** (Morphine Sulfate)
- **MGSO4** (Magnesium Sulfate)
- **MS** (Morphine sulphate, mental status, etc)
- **ARA-A & ARA-C** (Cytarabine)
- **OXY** (OXY-IR, Oxycontin, Oxycodone & Oxytocin)
- **MTX** (Methotrexate)
- Medication Dosages:
  - Never Use Terminal Zeros (1.0)
  - Always Use Leading Zeros (0.5)