DMC
DETROIT MEDICAL CENTER

Tier 1000
System Administrative

Title:	The DMC Patient Medical Record	Page 1 of 2
Policy No:	1 MS 033	Effective Date: 12/01/2013

OBJECTIVE
This policy defines the composition of the Detroit Medical Center's (DMC's) patient medical record, created in the course of providing comprehensive, quality health care services.

SCOPE
All Detroit Medical Center, Children's Hospital of Michigan, Detroit Receiving Hospital and University Health Center, DMC Surgery Hospital, Harper University Hospital, Hutzel Women's Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital Medical Staff, Clinicians, and Ancillary staff, who require a patient's medical record in which to document diagnostic or therapeutic services, as well as to reference previous health care services, are covered under this policy. Additionally, all Administrative and Support staff who must utilize a patient's medical record to perform their jobs are also covered under this policy.

POLICY
Consistent with DMC Medical Staff Bylaws, Rules and Regulations, the DMC shall maintain a comprehensive, integrated medical record for every patient who receives diagnostic or therapeutic services at any of its facilities. A patient's complete medical record, irrespective of the DMC facility where services were provided, shall be available for treatment, payment, operations, or medicolegal purposes. Each patient's medical record shall be indexed and stored in such manner as to promote access across the enterprise to the entire health record of a patient.

PROVISIONS
1. The DMC Patient Medical Record is a primary medical record, in that it is the principal repository for original and interfaced system information about a patient's health, including diagnoses and therapeutic treatments performed in various health care settings. It contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

2. Every person seeking health care at the DMC is assigned a single, unique number. This number, used to identify a patient and his/her records, links that patient across all DMC facilities, thus promoting an integrated, medical record, access to which by caregivers provides comprehensive patient medical information.

3. The DMC Patient Medical Record continues to evolve into a comprehensive, integrated electronic medical record (EMR), with patient information captured through a combination of digitally fed or digitally transmitted data and information, paper, and scanned original, paper-based documentation. This transition from paper-based to electronic records is occurring in stages, exemplified by the current availability of the following demographic and health information about patients across all DMC health care facilities in the Clinical Information System ("CIS"):

    - Admission, discharge and transfer (ADT) data;
    - Results, including laboratory and other diagnostic;
    - Transcribed reports, including histories and physicals, operative reports, consultations and discharge summaries;
    - Diagnostic imaging;
    - Clinician documentation reflective of the care provided including the surgical record
    - Clinic visit documentation (currently in progress for some clinics)

4. The DMC Patient Medical Record also includes documentation required by law and regulation, as well as data specified in the DMC Medical Staff Bylaws, Rules & Regulations. Only that information which documents the diagnostic and therapeutic services, and related information, that provides a complete picture of a patient's health status and well being shall be part of the DMC Patient Medical Record.

5. Data and information in the DMC Patient Medical Record is used to compile information to satisfy the needs of specific users, such as external reporting agencies (e.g., vital statistics, state-wide databases, registries, etc.).
6. The DMC Patient Medical Record is comprised of both Administrative and Clinical Data:

   Administrative Data include, but is not limited to:

   - patient identification, including demographic data and the name of any legally authorized representative;
   - newborn identification data;
   - financial data;
   - legal status (mental health patients);
   - consents for admission/treatment;
   - informed consents for operative and invasive procedures;
   - advance directives; and
   - release of information authorizations.
   - ethnicity

   Clinical Data, recorded by authorized health care providers, include, but is not limited to:

   - reason for admission/treatment;
   - history, including: chief complaint; present illness; allergies; past medical, family, psychosocial history; and review of systems;
   - emergency care provided to the patient prior to arrival, if any;
   - antepartum data;
   - newborn birth history;
   - problem list;
   - physical examination;
   - statement of impressions or conclusions drawn from the history and physical examination;
   - diagnostic and therapeutic orders;
   - patient assessment, re-assessment and care plans;
   - goals of treatment and treatment plan;
   - clinical observations and patient's responses to care;
   - progress notes and nurses notes;
   - operative and invasive procedure information, including pre-anesthesia, anesthesia, and post-anesthesia information;
   - labor, delivery and postpartum data;
   - laboratory and pathology results;
   - diagnostic imaging findings and impressions;
   - vital signs;
   - fetal tracings;
   - medication administration, including dosage and any adverse drug reaction;
   - diagnostic and therapeutic results, such as electrocardiograms, electromyograms, EEGs, etc.;
   - consultation results;
   - laboratory results;
   - documentation of ancillary services, such as:
     - cardiac rehabilitation services;
     - nutritional assessments;

- occupational therapy services;
- physical therapy services;
- recreational therapy services;
- speech/language pathology services;
- rehabilitation services;
- respiratory therapy;
- social services reports;
- behavioral health services;
- medication counseling;
- patient/family education; and
- discharge planning.

- a listing of all relevant conclusions, final diagnoses and procedures;
- discharge planning;
- any referrals and communications made to external care providers and to community agencies;
- patient/family education;
- discharge summary, final progress note or transfer summary;
- autopsy results;
- copies of records from other health care providers;
- growth chart;
- immunizations;
- medication profiles; and
- clinic notes.
- Problem list
- Diagnosis list (coded)
- Discharge notes
- Height/weight/calculated body mass
- Allergy
- Medication list and medication reconciliation

7. Additional documentation may be stored with the medical record for convenience. Examples include release of information authorizations and various court and other legal documents.

8. Peer Review documents, Quality Review documents, and Incident Reports are not a part of the medical record and shall not reside in the medical record.

9. Documentation in the DMC Patient Medical Record may be maintained as paper, microform and electronic media.

10. In the event that data contained in any of the above formats is conflicting, the data that is contained in the electronic medical record (EMR) is the authoritative/accurate source (“Source of Truth”) of the patient’s record of care.

11. Data interfaced from other systems and/or devices to CIS is made available to a clinician who then provides an interpretation of that data (diagnostic data i.e. lab, EKG, etc.), and must document this in the medical record or validate the data prior to final posting to the medical record (i.e. device integration data such as heart rate, blood pressure, weight etc). Source data is not considered part of the DMC Patient Medical Record, and requires a specific release of information authorization from the patient for the release of this data.

REFERENCE

Sponsors: Health Information Management
DMC Medical Record Committee'
Medical Executive Committee
Joint Conference Committee Approval (2/24/04); JCC Revised: 8.24.10\

- AHIMA. 2001. Practice Brief: ""Definition of the Health Record for Legal Purposes," Chicago, IL.
- *Computers in Health Care.* 1992. "Aspects of the Computer-based Patient Record," Springer-Verlag, New York.
- K. Waters and G. Murphy. 1979. "Medical Records in Health Information", Aspen Systems Corporation, Germantown, MD.
- S. Murphy-Muth. 1987. "Medical Records: Management in a Changing Environment," Aspen Publishers, Rockville, MD.
- V. Slee, MD. 1996. "Slee's Health Care Terms, Third Edition", Tringa Press, St. Paul, MN.
- M. Abdelhak, S. Grostick, M. Hanken and E. Jacobs. 1996. "Health Information: Management of a Strategic Resource", W.B. Saunders Company, Philadelphia.
- DMC. 2001. Medical Staff Bylaws, Rules and Regulations
- The Joint Commission 2013 "Comprehensive Accreditation Manual for Hospitals," The Joint Commission, Oak Brook, IL.

ADMINISTRATIVE RESPONSIBILITY

- The Chief Medical Officer and the President of the Medical Staff shall have overall administrative responsibility for this policy.

- The Chiefs of Staff, the Specialist In Chiefs and the Hospital Presidents shall have day-to-day operational responsibility for this policy. The DMC Health Information Management Department shall have managerial oversight of the provisions of the policy.

- Final approval for the transition of patient medical information from paper to electronic form rests with the Senior Vice President, Chief Nursing Officer and Chief Medical Information Officer with concurrent approval of the DMC Medical Executive Committee.

APPROVAL
This policy has been approved and is duly authorized by Detroit Medical Center, Children's Hospital of Michigan, Detroit Receiving Hospital, DMC Surgery Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that it is in full force and effect.

REVIEW DATE
12/2016

SUPERSEDES
09/14/2004; 09/24/2010

KEY Search Words:

Please check one:
This policy is: ☐New ☒Reviewed ☐Revised

CHANGES

Sponsors: Health Information Management
DMC Medical Record Committee'
Medical Executive Committee
Joint Conference Committee Approval (2/24/04); JCC Revised: 8.24.10\