SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

Title: Health Record Completion & Documentation		☐ Policy ☒ Policy & Procedure ☐ Procedure Only ☐ Protocol Only
Policy Type:		
Medical		
Approval Authority Level: Medical Advisory Committee	Authority Area of Responsibility Health Information	
Date of Original Issue: March 2017	Revised Date: February 11, 2025	Next Review Date: February 11, 2028
Distribution: ☒ Hospital-Wide		
Related Policies: **Incomplete Record Policy; Administrative Closure of Charts; Authentication/Electronic Signature**		
Keywords: Documentation, Chart Completion, Health Record		
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Purpose:

A complete health record is essential in ensuring the best possible care is provided and documented in compliance with the *Public Hospitals Act* (1990), the *Medicine Act* (1991) and the *Health Insurance Act* (1990).

Policy:

Sault Area Hospital's (SAH) Health Records department monitors for completeness of health records and supporting documentation. The process compares the professional staff entries in the record against an established set of criteria derived from the following legislation: *Public Hospitals Act* (1990), the *Medicine Act* (1991) and the *Health Insurance Act* (1990). It is the responsibility of each professional staff to ensure accurate and timely completion of documentation which includes a date and signature. In the event of a deficiency SAH's Incomplete Record Management policy is initiated.

Procedure:

The content for the patient record will be in accordance with the *Public Hospitals Act*, Regulation 965 Hospital Management.

In-patient chart documentation is considered to be complete when the minimum recommended components exist as listed in **Appendix A**.

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Additionally, the following also apply to patient discharges:

- Complete the Discharge Summary for all inpatient records. For shorter admissions of less than 24 hours, such as normal newborns and normal deliveries, a brief note documenting follow-up plans, discharge diagnosis, and status at discharge shall suffice

- Complete a discharge summary for a patient discharged from an Acute Unit (such as ICU or 3C) to a Non Acute Unit (such as Rehab or Mental Health). The dictating provider can use the discharge summary as the admission note for the receiving unit. Dictator must indicate at the start of the dictation that the discharge summary will be also used as the admission note for the Non Acute transfer, ensuring the dictation is attached to the correct encounter(s)

Out-Patient chart documentation is considered to be complete when the minimum components as outlined in **Appendix B** exist.

Documentation

Providers are required to utilize Meditech Expanse for documentation purposes; any documentation done outside of Meditech Expanse will not be considered valid. The sole exception will occur during downtime procedures.

pDoc and backend dictated reports will remain in draft status and are not distributed outside of Sault Area Hospital until the dictating provider reviews and electronically signs documents.

Timeline for Chart Completion

The Health Record must be completed within 7 days of the patient discharge, visit, and/or treatment, unless a defined timeframe is specified under Appendix A or Appendix B.

Clinical Record Analysis and Audit Process

Health Records staff will analyze and audit the inpatient, emergency, and day surgery records for the chart documents described in Appendix A and Appendix B.

Deficiencies will be assigned to the Most Responsible Physician in the electronic tracking system where information is determined to be incomplete.

Each entry in a patient's health record will be dated and authenticated by the author. This applies to each entry on a single document when it contains entries authorized by more than one person.

Responsibility for chart completion lies with the Most Responsible Physician who is listed as the Attending Physician, until this responsibility is transferred in writing to another physician.

Supportive Data / Definitions:

pDoc: Physician Documentation	

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Terminology: Definition	**Terminology:** Definition

References:

1. *Public Hospitals Act* (1990)
2. *Medicine Act* (1991)
3. *Health Insurance Act* (1990)

APPENDICES:

Appendix A: Minimum Requirements for In-Patient Chart Documentation
Appendix B: Out-Patient Documentation Requirements

Revision History:

Date:	Signing Authority: Name / Title
March 2017	Medical Advisory Committee
September 2021	Medical Advisory Committee
February 11, 2025	Medical Advisory Committee

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Appendix A: Minimum Requirements for In-Patient Chart Documentation

Document	Recommended Completion Timeline	Main Components	Comments
History and Physical	Within 24 hours of admission	• History of present illness • Past medical history • Family and Social history • Functional inquiry including allergies and medications • Physical findings • Provisional diagnosis	Authenticated by Most Responsible Physician
Consultation Report		• Reason for consult • Findings of examination • Provisional diagnosis • Treatment plan	Authenticated by Consultant
Orders		• Must be signed	Authenticated by Most Responsible Physician
Progress Notes	Daily	• Reflects patient status and changes	
Anesthetic Report	After Procedure	As per form	Document on chart
Operative Report	Within 24 hours of surgery	• Date of surgery • Names of surgeon, anesthetist and assistants • Pre-operative diagnosis • Post-operative diagnosis • Description of procedure • Tissue removed • Condition at completion	Authenticated by Surgeon
Labour, Delivery and Post-Partum Summary	End of each episode of care	As per form	Completed document on chart
Discharge Summary ***see Procedure section of policy**		• Discharge diagnosis for all SI account types • Must have signed order	Authenticated by Attending Physician
Certificate of Death	At time of death	As per form	Document on chart

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Appendix B: Out-Patient Documentation Requirements

Document	Completion Timeline	Main Components	Comments
EMERGENCY VISITS			
Emergency Record	At discharge	• Reason for visit • Examination and findings • Diagnosis • Treatment Plan • Patient Disposition	Completed and Signed by Attending Physician
DAYSURGERY VISITS			
History and Physical	Prior to Surgery	• History of present illness • Past medical history • Family and social history • Functional inquiry including allergies and medications • Physical findings for all body systems • Provisional diagnosis	Authenticated by physician. If older than 60 days, must be updated prior to surgery.
Anesthetic Report	Prior to discharge	As per form	
Operative Report	Within 24 hours of surgery	• Date of surgery • Names of surgeon, anesthetist and assistants • Pre-Operative diagnosis • Post-Operative diagnosis • Description of procedure • Tissue removed • Condition at completion	Authenticated by Professional Staff
OUT-PATIENT VISIT - NEW CONSULTATION			
Consultation Note	Requirements determined by Program Service	• Reason for visit • Findings of examination • Diagnosis • Treatment plan and patient disposition • Complete treatment record	Authenticated by Attending Physician
OUT-PATIENT VISIT - FOLLOW UP/REPEAT			
Out-Patient Records	At visit	As per form	Completed by Attending Physician
Clinic Note	Requirements determined by Program Service	• Ongoing status updates or when there is a change in patient condition or treatment	Authenticated by Attending Physician

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Procedure Note	Requirements determined by Program Service	• Type of Procedure • Findings and/or Complications • Follow up care	Authenticated by Attending Physician
OUT-PATIENT VISIT – DENTAL SURGERY			
History and Physical		• History of present illness • Past medical history • Family and social history • Functional inquiry including allergies and medications • Physical findings for all body systems Provisional diagnosis	Anesthetic Record can be used for local dentists
Anesthetic Report	Prior to discharge	As per form	
Department of Dentistry Form		As per form	Authenticated by Dentist

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