Scope
This policy applies to all University of Western States (UWS) health center employees who are responsible for documentation standards, including but not limited to clinicians and office management staff.

Purpose
Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. Medical record documentation guidelines vary between state boards, and with university risk management insurance. The UWS health center has adopted standards using the National Committee for Quality Assurance (NCQA) Guidelines to assist in defining university documentation standards for practice.

Definitions

- **Electronic Health Record (EHR):** Patient medical information stored in a digital format.
- **National Committee for Quality Assurance (NCQA):** Organization dedicated to improving health care quality through the administration of evidence-based standards, measures, and accreditation.

Policy
UWS health center clinicians and team members document the following in the Electronic Health Record (EHR):

- The patient's name or ID number is included on every page of the health record.
- Author identification is included in all medical record entries and may be in the form of a handwritten signature, unique electronic identifier, or initials.
- The date (All entries must be dated).
- Significant illnesses and medical conditions are indicated in the health record.
- Past medical history is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- The history and physical examination identify appropriate subjective and objective information pertinent to the patient's presenting complaints.
- Working diagnoses are consistent with the findings.
- Treatment plans are consistent with the diagnoses.
- The request or referral if a consultation is requested, or the patient is referred elsewhere.
- There is no evidence that the patient is subject to inappropriate risk by a diagnostic or therapeutic procedure through the informed consent process.
- Personal biographical data includes the address, employer, home and work telephone numbers, and marital status.
- Follow-up care, calls, or visits when indicated on encounter forms or as notations in notes. The specific time of return is noted in weeks, months, or as needed.

- Unresolved health concerns from previous UWS health center visits are addressed in subsequent visits.
- Consultation and diagnostic testing (e.g., imaging, labs, electrodiagnostic) reports filed in the chart are signed by the practitioner who ordered them to signify review. Review and signature or initial by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal test results have an explicit notation in the record of follow-up plans.
- Evidence that preventive screening and services are offered in accordance with the treating clinicians' professional standards.

Related Policies: Policy 1412 Minimum Documentation Requirements for Chiropractic Services
Policy 1413 Minimum Documentation Requirements for Naturopathic Services
Policy 1414 Patient Intake and History