Medical Records Annual Education

2025

History & Physical Requirements

- Complete on all admissions (Inpatient, Observation, Antepartum including triage, surgical, IR and Infusion) within 24 hours, prior to surgery and/or discharge
- For elective surgical admissions- note can be from office within the last 30 days as long as **UPDATE** completed upon admission
- Must have date and time completed and signed by Attending when done by designee including UPDATED forms
- Ensure the proper note type being used: Admit vs Consult vs Outpatient Assessment (IR specific)
- Minimum documentation:
  - Reason for admission / chief complaint / HPI
  - Pertinent Medical / Surgical / Social history / Code status
  - Allergies
  - Home medication reconciliation
  - Appropriate physical exam
  - Pertinent lab / radiology / cardiology study findings / interpretations
  - Assessment and Plan including anticipated length of stay

Minimum Provider Documentation Requirements

Length of Hospital Stay	Soarian H&P	Soarian Progress Notes	Soarian Discharge Summary
In House Stay and Discharged Alive			
<24 hours	Yes	Yes	No –only if progress note updates status
>24hrs (Soarian Clinical Discharge Summary)	Yes Newborn vaginal short stay – Soarian Discharge summary only	Yes	Newborn- Yes Uncomplicated OB delivery –Yes
>48 hours including Adult Minor/Outpatient	Yes	Yes	Yes
In Hospital Death			
<24hours from admission	Yes	Progress Note: Death pronouncement required	No
>24 Hours	Yes	Yes	Yes
Elective / Scheduled Surgery			
<24 Hours	Yes- office copy is acceptable if <30 days old, validated & signed on day of surgery	Yes, when needed	No, as long as post-op progress note updates plan
>24 Hours	Yes- office copy is acceptable if <30 days old, validated & signed on day of surgery	Yes	Yes

*Interventional radiology requires an OP Assessment for those encounters with no anesthesia Rules/Regs. 2.3

*Medical Record documentation requirements in line with NIAHO Accreditation Requirements MR.7 > SR.1 thru SR.9.

Provider Documentation Completion Expectations- All in Soarian EMR

Document Type	Initial Completion (Attending, NP, PA or Resident)	Final Authentication / Co-sign by Attending
H&P	<24 Hours from admit	72 hours
Consult	<24 hours from consult	7 days
Progress Note	Daily	Daily
Procedure Note (includes Vaginal delivery)	Time of procedure completion	72 hours
Brief Operative Note-(not needed if complete OP done before patient leaves PACU)	Prior to patient leaving the PACU	72 hours
Operative Note (includes C-section) (Rules/Regs 2.5.1)	<24 hours	72 hours
Discharge Summary (Rules/Regs 2.5.5)	At discharge	72 hours
Post Discharge Coding Queries (Rules/Regs 2.5.1)	Within 7 days of assignment	7 days
Clinical Documentation Clarification (Rules/Regs 2.5.1)	Within 24 hours (PA / Resident – unable to complete due to system limitations)	24hrs of assignment

Co-signature requirements for Orders

Order	Ordering Provider	Attending Co-Signature Needed Y/N
Admit to IP	RESIDENT/NP/PA	Y
Assigned to OBS	RESIDENT/NP/PA	Y
Assigned to OP	RESIDENT/NP/PA	Y

Order	Ordering Provider
Telephone Order	Needs to be signed by the ordering provider within 24 hours
Written /Paper Order	When transcribed into CPOE, co-sign not needed

Hospital Policy (P0036): Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into an electronic prescribing system without delaying treatment. Verbal orders are not to be used for the convenience of the ordering practitioner.