EXAMINING THE MEDICAL RECORD

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Date: April 24, 1991

To: Linda Creps
   Director of Medical Information Services
   University of Michigan Medical Center

From: Kristin Missil & David H. Schultz
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Subject: Medical Record Project

Foreword:

Medical Information Services of the University of Michigan Medical Center is striving to update the organization of the medical record. The goal is to have a medical record that accurately reflects the state of medical technology in the 90's. However, problems with the current medical record must be identified before the improvements can occur.

Consequently, Linda Creps assigned to us the task of investigating the problems associated with the organization of the current medical record. The purpose of this report is to recommend a standardized order to be used by the ward clerks and the inpatient analysts to eliminate unnecessary rework. This report also recommends keeping the current folder format, using the prongs on the left side of the folder.

Summary:

The current order for the closing of the medical records by the ward clerks and the order of the record for the inpatient analysts are different in the last three sections of the record (BEDSIDE, NURSING, and OUTSIDE REPORTS). The difference in orders causes unnecessary rework and inconsistency. A standardized order for both the ward clerks and inpatient analysts will eliminate the rework.

In addition, we recommend keeping the current format of the medical record folder. Other designs would be costly to purchase.
and implement. However, the folder could be used more effectively, making use of the metal prongs on the left side.

During our investigation, we identified five other problem areas dealing with the medical record (Appendix A). There are no recommendations to these additional five problems due to our short background in medical records and the controversy involved with them. However, we suggest that the problems be investigated by a research group qualified in the medical field.

Discussion:

Differing Orders

The rework performed by the inpatient analysts is the result of the difference between the mandated order formats issued to the ward clerks and the analysts. The last three sections in the format specified for the floor clerks are ordered BEDSIDE, NURSING, OUTSIDE REPORTS. The last three sections in the inpatient analyst format are ordered NURSING, OUTSIDE REPORTS, BEDSIDE.

Therefore, in addition to the duty of assimilating the new information into the medical record, the analyst must reorder the document into the issued inpatient analyst order from the discharge order (from Appendix B to Appendix C). This rework is unnecessary.

Inpatient analysts claimed that the records came from the floor clerks "out of order." However, during the interviews that were conducted, neither the inpatient analysts nor the floor clerks were familiar with each other's orders.

In a sampling survey of 31 medical records it was clear that the format issued to the ward clerks was not being followed. The NURSING FORMS and the BEDSIDE CHARTS sections were often out of order. Although the discharge misfiled order resembled the specified inpatient analyst order, the inconsistency in the order of the records coming down to the inpatient analysts from the floor clerks caused difficulty for the analysts.

A potential order to be used for the official "standardized" order is the current inpatient analyst order. It appears that the
specified order of the medical record on the three-ring binder during 
the patient's stay resembles the inpatient analyst order.

Format of the Medical Record Folder

The current medical record has all the documents attached to 
the right side at the top by a two pronged soft-metal bracket that 
secures the documents one on top of the other. This causes great 
difficulty in identifying and adding new documents with the 
inpatient portion below the outpatient. However, after analyzing the 
pros and cons of six other formats, we were not able to find an 
alternative that would be cost efficient, feasible to implement, and 
would not provide a storage problem.

The current folder can be used more efficiently by taking 
advantage of the clip on the left side of the record. The prongs on 
the left side of the folder are shorter than the prongs on the right. 
However, the prongs on the left can be used by the ward clerks for 
the attachment of new documents when returning the record to the 
inpatient analysts. By attaching new documents to the left side of 
the folder, the analysts will be able to easily identify new 
information and will only have to lift up the outpatient section for 
the attachment of these documents. Further investigation of using 
the prongs on the left side might indicate a time savings for the 
analysts.

Other problem areas

Our research has uncovered several other problems that fall 
beyond the scope of our expertise. To make suggestions for 
improvements would be doing so without having the proper 
background or qualifications. However, the identification of these 
problems can be useful for future investigations. These problems 
are listed in Appendix A so that you may assign them to more 
qualified project group.

Conclusion:

We recommend the adoption of a standardized order to be 
implemented by both the ward clerks and the inpatient analysts. A 
standard order would promote consistency in the order that 
documents are filed in the medical record and would eliminate
unnecessary rework. The inpatient analyst order appears to be a feasible standard order because it resembles the order of the medical record during the patient's stay.

In addition, we recommend keeping the current folder format of the medical record folder. Other designs would be costly to purchase and difficult to implement. However, the folder can be used more effectively, making use of the shorter metal prongs on the left side. The ward clerks can place the documents that they have just closed out on the prongs on the left to make it easier for the inpatient analyst to identify new documents. Further investigation is suggested.
Executive Summary - Appendix A
Problems recognized that are not covered in this report

1. SHADOW RECORDS. Departments such as OB/GYN and Neurology feel the need to have their own shadow record systems. The main reason for this need is quick retrieval of information. However, OB/GYN is sometimes keeping original documents such as the amniocentesis reports in the shadow record, instead of copies of the documents. The missing information in the official medical record poses a serious threat to the patient in an emergency situation.

2. STANDARDIZATION OF FORMS. Sectionalization clerks are not able to quickly recognize where to attach "nonofficial" documents from the various clinics. There were many requests for all forms to have the patient's name and registration number in the same place on every form. A request was made to condense lab reports so that the amount of blank space would be dramatically reduced. This decrease in unused space would cause the records to contain less pages. In addition, the different paper sizes for lab reports cause some documents to stick out.

3. CREATION OF NEW SECTIONS. The clinics would like to have their own separate sections of the record to facilitate retrieval of pertinent information. This request is infeasible would necessitate a major overhaul in the record design. However, a "prenatal" tab was unofficially added to the medical record. The sectionalization clerks do not deal with filing documents under this tab.

4. AMBULATORY CARE. This problem came in discussion with MPRO and further research uncovered that an additional tab was added to the outpatient section of the medical record.

5. SIZE. For many individual records, the amount of information compiled causes the medical record to be several volumes long. The volumes are very inconvenient to transport the records from department to department. Locating individual documents within the various volumes was said to be difficult, since only one set of tabs was used for all the volumes. In addition, we observed several records to be thicker than the maximum of 2 inches.

The problems mentioned here are those that either fell outside the scope of our project or outside the scope of our expertise. While we have made no suggestions on improving them, we do recommend a more qualified individual or group research these problems.
Introduction

Keeping medical records organized and complete has proven to be a challenging task for The Department of Medical Information Services using the current medical record format. In order to provide quality patient care, orderly medical records are of concern.

The intent of this study is to identify problems with the current medical record format and make recommendations so that the medical record at the University of Michigan Medical Center is organized to reflect the practice of medicine in the 90's, that promotes standardization of the record and eliminates unnecessary rework.
Background

On October 22, 1990 a meeting with the project's client marked the beginning of the Medical Record Project. Present at the first meeting were the client, Linda Creps - Director of Medical Information Systems, Ann Oxford - Associate Director of Medical Information Systems, and Shirley Percy - Supervisor of Record Retrieval. The medical record was introduced to the project team.

Following the first meeting with the client, the project team set up meetings with several departments within the University of Medical Center to identify problem areas and gather information about the medical record. Each meeting familiarized the project team with the uses of medical record. These meetings are briefly listed below.

MPRO and Billing
Sectionalization Clerks
Inpatient Analysts
Inpatient Analysts Supervisor
OB/GYN Clinic - Shadow records
Neurology - Shadow records
Satellite Record Room - Internal Medicine
Ward clerk on floor 6A
One Day Surgery
Dr. Neparko - Medical Records Workshop
Clerical Services

During the interviews and observations, the project team was able to identify several problem areas.

Departments such as OB/GYN and Neurology feel the need to have their own shadow record systems. The main reason for this need is quick retrieval of information. However, OB/GYN is sometimes keeping original documents such as the amniocentesis reports in the shadow record, instead of copies of the documents. The missing information in the official medical record poses a serious threat to the patient in an emergency situation.

Sectionalization clerks are not able to quickly recognize where to attach "nonofficial" documents from the various clinics. There were many requests for all forms to have the patient's name and registration number in the same place on every form. A request was
Background - continued

made to condense lab reports so that the amount of blank space would be dramatically reduced. This decrease in unused space would cause the records to contain less pages. In addition, the different paper sizes for lab reports cause some documents to stick out.

The clinics would like to have their own separate sections of the record to facilitate retrieval of pertinent information. This request is infeasible would necessitate a major overhaul in the record design. However, a "prenatal" tab was unofficially added to the medical record. The sectionalization clerks do not deal with filing documents under this tab.

This problem came in discussion with MPRO and further research uncovered that an additional tab was added to the outpatient section of the medical record.

For many individual records, the amount of information compiled causes the medical record to be several volumes long. The volumes are very inconvenient to transport the records from department to department. Locating individual documents within the various volumes was said to be difficult, since only one set of tabs was used for all the volumes. In addition, the project team observed several records to be thicker than the maximum of 2 inches. The thickness causes straightening of the wire prongs be done with pliers.

Currently, there are three separate specified orders of the record: during the patient's stay, discharge, and inpatient analyst. The reordering of documents creates much unnecessary rework. In addition, the three orders cause inconsistency in the order that the reports are filed.

Removing and attaching reports on the medical record is inconvenient and time consuming. In order to file documents in the inpatient portion of the record, the entire outpatient portion must be lifted off.

On Wednesday, November 7th, 1990, the project team attended a medical record workshop meeting, and compiled more information
regarding potential areas for improvement of the medical record. See Appendix I for the list of "ideal" characteristics of the medical record.

After reviewing the 'characteristics of the perfect medical record,' interviews, and observations, the project team focused on two problems of the medical record:

1. Rework caused by differing specified orders
2. The design of the folder.
DIFFERING ORDERS

On November 8th, 1990 the project team met with Mary Calhoun, one of the inpatient analysts that works in the University of Michigan Medical Center. Among the problems that said to encounter was the fact that the inpatient record when coming down from the floor was not being closed out quite correctly by the ward clerks. There were documents that were placed out of order as well as entire sections that were not where they should be. Of primary concern was that the OR reports were never where they were supposed to be.

Later in the week, the project team met with a ward clerk on 6A and watched her close out the inpatient record. She showed the research group the format she was to follow and demonstrated how the process is done. The clerk's task included verifying that all documents were present with the correct name and registration number, punching holes in documents that had holes only for the three-ring binder used during the patient's stay, and transferring the documents onto the medical record from the binder. Although the clerk reordered some of the documents, order was not a main concern.

Joelle Moroz and Colleen Kapp felt that the main priority of the floor clerks when closing out the record is to make sure all appropriate documents are present with the correct patient name and registration number appearing on all reports. It was implied that if more time were spent by the ward clerks ordering the reports, the verification of the presence of all documents would be jeopardized. As a result the job of placing the reports in order does not get done with the accuracy and efficiency. From the quick manner in which the ward clerk performed this task it is easy to see why the inpatient analysts find many 'misplaced' forms.

The project team then researched the two specified inpatient orders, one by the ward clerks and the other by the inpatient analysts. The orders are identical except for the last three sections. The ward clerks are supposed to close out the record with the bedside chart followed by the nursing forms and outside reports. These sections are moved back by the inpatient analysts so that the nursing forms and outside reports precede the bedside chart. In effect, the difference in orders creates unnecessary rework for the inpatient analysts.
The project team uncovered another reason explaining the analysts' complaints of incorrectly filed reports by the ward clerks in a meeting with Joelle Moroz and Colleen Kapp. Even though on the printed format order for the ward clerk specifies that the OR section should be moved from the bottom of the chart to the middle of the record by the ward clerk, Joelle Moroz and Colleen Kapp claim that the OR section is not being moved up.

In order to clarify the actual order of documents that were in the medical record after being closed out by floor clerks, the project team conducted a survey. Please see following pages.
Inpatient Analyst survey

Methodology

Over a one week period we asked the inpatient analyst to sample the medical records that were being delivered from the floors. The analysts recorded the order of documents in the medical record, after the records were closed by the ward clerks. The purpose of this survey was to investigate the actual order of documents that the floor clerks assembled after patient discharge. A total of 31 records were sampled.

Results

A document was considered to be "out of order" if it appeared before a document that it was supposed to follow. Please refer to the table on the next page.
TABLE 1. FILING ERRORS IN INPATIENT RECORD AFTER DISCHARGE

<table>
<thead>
<tr>
<th>DOCUMENT</th>
<th># errors</th>
<th>present</th>
<th>% misfiled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Notes (yellow)</td>
<td>0</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Discharge Notes - F/UP Order Sheet</td>
<td>1</td>
<td>26</td>
<td>04%</td>
</tr>
<tr>
<td>Discharge Planning Guides-Summaries</td>
<td>7</td>
<td>12</td>
<td>58%</td>
</tr>
<tr>
<td>Consultation Sheets</td>
<td>1</td>
<td>26</td>
<td>04%</td>
</tr>
<tr>
<td>X-Rays Radiology Reports</td>
<td>3</td>
<td>21</td>
<td>14%</td>
</tr>
<tr>
<td>Labs, Special Reports, EKG's</td>
<td>3</td>
<td>29</td>
<td>10%</td>
</tr>
<tr>
<td>OR Section</td>
<td>2</td>
<td>23</td>
<td>09%</td>
</tr>
<tr>
<td>Checklist</td>
<td>2</td>
<td>15</td>
<td>13%</td>
</tr>
<tr>
<td>Anesthesia Record</td>
<td>5</td>
<td>19</td>
<td>26%</td>
</tr>
<tr>
<td>OR Record (white)</td>
<td>7</td>
<td>19</td>
<td>37%</td>
</tr>
<tr>
<td>Operative report (grey typed)</td>
<td>4</td>
<td>6</td>
<td>67%</td>
</tr>
<tr>
<td>Recovery room</td>
<td>0</td>
<td>11</td>
<td>0%</td>
</tr>
<tr>
<td>Patient Charge Items</td>
<td>2</td>
<td>17</td>
<td>12%</td>
</tr>
<tr>
<td>Pathology</td>
<td>0</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Soft Care</td>
<td>0</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>Physician Orders</td>
<td>1</td>
<td>31</td>
<td>3%</td>
</tr>
<tr>
<td>TPN Order Sheets, Nutrition Orders</td>
<td>0</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Dx Order Sheets</td>
<td>0</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Bedside Chart</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>PCA flow Sheets</td>
<td>0</td>
<td>15</td>
<td>0%</td>
</tr>
<tr>
<td>Recurrent medication record</td>
<td>8</td>
<td>18</td>
<td>45%</td>
</tr>
<tr>
<td>IV Medication Record</td>
<td>7</td>
<td>13</td>
<td>54%</td>
</tr>
<tr>
<td>ADLs</td>
<td>6</td>
<td>16</td>
<td>38%</td>
</tr>
<tr>
<td>Flow Sheets</td>
<td>7</td>
<td>22</td>
<td>32%</td>
</tr>
<tr>
<td>Nursing Forms</td>
<td>24</td>
<td>28</td>
<td>86%</td>
</tr>
<tr>
<td>Medication</td>
<td>22</td>
<td>25</td>
<td>88%</td>
</tr>
<tr>
<td>Problem List</td>
<td>18</td>
<td>21</td>
<td>86%</td>
</tr>
<tr>
<td>ICU, Patient Care Summaries</td>
<td>0</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Diabetic Records</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Outside Reports</td>
<td>0</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Chronological</td>
<td></td>
<td></td>
<td>45%</td>
</tr>
<tr>
<td>Reverse Chronological</td>
<td></td>
<td></td>
<td>32%</td>
</tr>
<tr>
<td>Not recorded</td>
<td></td>
<td></td>
<td>23%</td>
</tr>
</tbody>
</table>
Analysis of survey

During the month of February, with the assistance of the inpatient analysts the project team conducted a sampling survey to find out in what order the clerks were sending down the record. From the survey the project team was able to target the areas that were being closed out incorrectly as per the standard for discharging the patient.

The "problem area" the survey uncovered was that the clerks were not moving the bedside chart ahead of the nursing forms as specified in the discharge order format. In over 3/4 of all our samples, the NURSING FORMS and BEDSIDE FORMS were misfiled, with the entire sections out of order as well as the documents within the sections misfiled.

The analysts organize the nursing forms ahead of bedside charts, so the ward clerk 'misfiling' order was actually the correct inpatient analyst order.

Surprisingly, the OR section as a whole was filed where it should be, despite claims by the inpatient analysts that it rarely comes down from the floor filed correctly. Before the survey, we spoke to Colleen Kapp and Joelle Moroz about this claim and they confirmed that the OR section was not being moved up, contrary to the results of the survey. Furthermore, the survey suggested that the documents within the OR section are not closed out in the correct order.

Another area that deserves mentioning is the Discharge Planning Guides -- Summaries which are always placed near the top but in the wrong order 58% of the time.

The research group also surveyed whether or not the record was coming down in chronological order or reverse chronological order. Colleen Kapp indicated that the discharge order is mostly chronological with the exception of the nursing flow sheets and medical administration forms which are both filed in reverse chronological order. The results of the survey show that almost 1/3 of the time the records were closed out incorrectly in mostly reverse chronological order.
Recommendations - DIFFERING ORDERS

The different specified orders for discharge and for inpatient analysts cause unnecessary rework. Therefore, the implementation of a standardized order is suggested. It appears that the inpatient analyst order is feasible for the standardized order, since the inpatient analysts organize the record similar to the specified order of the record during the patient's stay.
MEDICAL RECORD FOLDER FORMAT

The medical record folder has been a source of some problems for the people who use it. The problem most often cited is the difficulty and inconvenience in attaching or removing loose sheets. To accomplish the attachment or removing of loose sheets in thick records, often pliers are used to straighten the wire prongs. Other complaints include the fading of the color in code, the wire prongs are too sharp, and not enough reinforcement when records are extra-thick.

The project team undertook the task of creating and investigating several alternate formats and weighed the pros and cons of each design. The format of medical records from other hospitals aided us in creating other designs. Cooper Hospital uses the prongs on both sides of the folder, for example. The criteria of the designs included ease in accessibility and attachment of loose sheets, cost, storage, and the ease of implementation. Please refer to the figures on the next page.
Over the course of our project we analyzed and researched the benefits and consequences of changing the current medical record folder design. The seven designs that we researched are:

1. Same format 3-ring binders on side
2. Two sided format Two metal prongs on top
3. Same format 2-ring binders on top
4. Same format 1 pin in left corner
5. Two sided format Two 2-ring binders on top
6. Same format Notebook
The current design
One sided format
Two metal prongs on top
List of Pro's and Con's for Designs of Folder Format

Design #1
Description: A one sided format with three ring binders on the left side

PROS: Easier to insert one loose sheet
     Easier to locate one document or report

CONS: Cost - very expensive
     Need to punch to new holes in every document
     Storage problems

Design #2
Description: A two sided format with the two metal prongs at the top of each side

PROS: Easier to insert than the present format
     Could look at inpatient or outpatient without going through entire record
     Could use current medical record folder

CONS: Maximum thickness must be decreased - more volumes
     More pressure on spine of record - more prone to tear
     Unattached loose sheet - can't rest on top

Design #3
Description: A one side format with two ring binders on top

PROS: Easier to insert one loose sheet
     Easier to locate one document or report
     Would be easy to adapt to previous two hole system

CONS: Very expensive
     Storage

Design #4
Description: A one sided format with one pin in the left corner

PROS: Less expensive
CONS: All problems as with current two prong system
Adoption to a one hole system from a two hole system

Pro’s and Con’s for Designs - continued

Would probably fall apart very easily

Design #5
Description: A two sided format with two 2 ring binders on top of each side

PROS: Easier to insert one loose sheet
       Easier to locate one document or report
       Would be easy to adapt to previous two hole system

CONS: Cost - very expensive
       Storage

Design #6
Description: A one sided format contained within a notebook

PROS: Easy to transport and carry
       Easy to insert a new sheet
       Easy to flip through

CONS: Size restriction—many volumes for one record
       Cost
       Storage
       Must have standard size sheets

Design #7
Description: A one side format with two metal prongs at the top

PROS: Already implemented
       Familiarity
       Cost - no additional

CONS: Must lift up several documents to insert one
       Difficult to flip through
Brief Analysis

After consulting with many supply stores see Appendix IV, the project team determined that the alternate designs with binders would have to be specially ordered, being many times more expensive than the current folder format. The other main concern about the designs with binders is the difficulty of changing over to the new system regarding time to implement and storage space. Therefore, although the binders facilitate the attachment or removing of individual documents, binders were not considered feasible.

Although the two-sided prong format reduced the number of pages that have to be lifted off the prongs to file a document, the design was ruled out. The spine of the folder experiences more stress and would be more prone to tear, even with reinforcements. Furthermore, with shorter prongs on the left side of the record, the maximum thickness of records with the two-sided prong format must be greatly decreased, making additional volumes necessary and thus causing more inconvenience.
Recommendations - MEDICAL RECORD DESIGN

Due mainly to the objective of finding a cost efficient solution that could be easily implemented, the project team recommends remaining with the current format.

However, the format could be used more efficiently. The other side could be used by the ward clerks. When they are done closing out the record on the floor, instead of placing it within the record where analysts will have to find the documents and then reorder the reports. Therefore, using the prongs on the other side of the folder will make it easier for the inpatient analyst to locate the new information.

A future investigation of left prong use is recommended to examine time savings for the inpatient analysts.
ACTION PLAN

To implement the recommendations suggested in this report, the plan of action consists of two steps.

1) Implement a standard order for ward clerks and inpatient analysts. The standard order will eliminate rework and promote consistency. The current inpatient analyst order seem feasible to be used for the standard order. This order should be approved by doctors at a medical record workgroup, and by both Medical Information Services and Clerical Services.

2) Keep current record format. Prongs on the left side of the folder should be used by the ward clerks to attach reports from the patient's recent stay. Further investigation of potential time savings for inpatient analysts is suggested.
Each category is to be placed in chronological order from admission (on top) through discharge (on bottom).

**PATIENT NOTES DIVIDER**
- Face Sheet
- Hypersensitivity Sheet
- Whole Body Gift Statement
- Anatomical Gift Statement
- Organ Donation Specification and Permission Log
- Death Notice
- Funeral Director Notification of Infection Control Precautions
- Survival Flight Notes
- Emergency Room Notes
- Concurrent Coding Document
- Pre-admission Continued Review Form
- Nursing Admission and Discharge Planning
- Nursing Admission Assessment
- Nursing Care Plan
- Inpatient Notes
- Discharge Note/Follow-Up Order Form

**DISCHARGE PLANNING DIVIDER**
- Nursing Discharge Planning Guide
- Nursing Discharge Summary
- Nursing Discharge Summary - Continuation
- Nursing Transfer Summary

**CONSULTATION SHEETS DIVIDER**
- Consultation/Referral Sheets

Reports (sigmoidoscopies, gastroscopies, etc.) or Progress Notes (i.e., P.T. or O.T.) based on initial Consultation or Refer Sheets are to be filed immediately behind the Consultation or Refer Sheet requesting them (i.e., a sigmoidoscopy report is filed immediately behind the Consultation or Refer Sheet requesting it).

Should a biopsy be done, however, the resulting Pathology Report is filed under the Special Tests and Procedures divider, as is the permit (Consent) form related to that procedure.

Reports not accompanied by initial Consultation or Refer Sheets may be filed by category under the Special Tests and Procedures divider.

**X-RAY REPORT DIVIDER**
- Pink Radiology Reports

**LABORATORY REPORTS DIVIDER**
- Lab Flow Sheets
- Temporary Lab (green)
- Permanent Lab (yellow)
- Discharge Summary (pink)
- Blood Blank Transfusion Record
- Arterial Blood Bas Reports and Interpretation Form

**SPECIAL TESTS AND PROCEDURE DIVIDER**
- Respiratory Therapy Patient Record

Special Reports (arrange in chronological order by CATEGORY; i.e., Nuclear Medicine Reports, etc. Respiratory Therapy and Physical Therapy Progress Notes without an initial consultation sheet are filed here.)
ADTU procedures are also filed here. They usually include the consent form, ADTU Record, Patient Charge Items, ADTU Report and Pathology Report. File each procedure as a separate unit on this order.
EKG DIVIDER
EKG Reports
*(Note - EKG permanent reports are black-white print. The temporary report, red and white print is discarded, except in some ICU's, when the permanent copy is filed on the chart.)*

O.R. PROCEDURES DIVIDER
Operative Forms - Each O.R./ADP Procedure is to be filed in the following order as a separate unit:
1. Operative Permit
2. Anesthesia Permit
3. O.R./ADP Checklist
4. Anesthesia Record
5. O.R. Record (white)
6. Operative Report (grey)
7. Recovery Room (PARU) Record (pink)
8. Patient Charge Items - O.R.
9. Patient Charge Items - Recovery Room
10. Pathology Report

- Soft Care Evaluation Form
- Therapeutic Bed Evaluation Form

PHYSICIAN ORDER SHEET DIVIDER
Admitting Physician Order Sheet
Admission/Transfer Order Sheet
Order Sheets

TPN/LAB REQUISITION DIVIDER
TPN Order Sheets
Enteral Nutrition Order Sheet
Lab Order Sheets

DIAGNOSTIC ORDER SHEET DIVIDER
Diagnostic Order Sheet

BEDSIDE CHART
Hypersensitivities Sheet
PCA Flowsheet
Recurrent Medication Record (blue)
Non-Recurrent Medication Record (green)
IV Fluid Medication Record (pink)
Patient Education Record
ADLs
Flow Sheet (TPR)

NURSING FORMS DIVIDER (blue forms)
Medication Titration Flowsheet
Problem List
Patient Education Record (if not kept on bedside)
24-Hour Patient Care Summary (used in ICUs)
Peritoneal Dialysis Record
Hemodialysis Record
Diabetic Record
Dietetics Record
Cardiac Flow Sheet

OUTPATIENT/OUTSIDE REPORTS DIVIDER
Outside Correspondence

Celluloid
Old Chart
CLOSED MEDICAL/SURGICAL RECORD ORDER

Face Sheet
Neoplasm sheet (gold)

OUTPATIENT PORTION

Summaries (green tab)
  Report of Actual or Suspected Child Abuse or Neglect
  Child Protection Team Summary
  Case Summaries (orange border)
  Attestation Statement
  Outpatient Summary or Letter (green border)
Continuity Reports (orange tab)
  Drug hypersensitivities (red and white striped border)
  Diagnosis Summary
  Procedures Summary
Outpatient Notes (white tab)
  Organ Donation Consent Form
  (place here if donor R/C at other facility)
  Ophthalmic Surgery Progress Sheet (blue)
  Orthoptic Evaluation (blue)
  Ophthalmology History Sheet (blue)
  Ophthalmology Refraction Sheet (blue)
  Ambulatory Surgery Patient Education Record
Outpatient Notes (white)
Lab Reports tab (lavender)
  Lab data sheets (purple)
Radiology Reports (pink tab)
EKG/EEG Reports (yellow tab)
Other reports (blue tab)
Outside reports (brown tab)

INPATIENT PORTION

Admission divider (white tab with admission and discharge dates)
  Autopsy Report
  Death Notice
  Funeral Director Notification
  Donation of Whole Body
  Anatomical Gift Donation Statement
  Organ Donation Specialization Permission Log
  Permission for Autopsy
  Telephone Permission Request (Autopsy)
  Preadmission/Continued Stay Review Form (PAR) (lt. blue or green)
  Concurrent Coding Worksheet (retain only most recent)
Flight Record
Survival Flight Nursing Record
Emergency Room Record
Emergency Services Trauma Care Sheet
Triage/Nursing Care Record
Nursing Care Record Continuation
Physician Admitting Slip
Permission for Clinical Research Studies
Inpatient Notes (yellow)
- Admission History & Physical Note
- Coronary ICU Nursing Assessment Form
- Nursing Admission Assessment-Critical Care Medicine Unit
- Nursing Admission Assessment
- Ambulatory Surgery Post-operative Discharge Instruction
- Nursing Care Plan
- Anesthesia Pre-Operative/Post-Operative Evaluation
- Inpatient Notes (yellow)
- Ophthalmology Progress Notes (yellow)
- Leave on Pass
- Nursing Services Discharge Planning Guide
- Discharge Planning Guideline
- Nursing Discharge/Transfer Summary
- Discharge Note or Death Note-on yellow progress notes
- Release Against Advice of Physician
- Discharge Note/Follow-up Orders

Patient’s Release Form for Refusal of Blood or Treatment
Request and Consent to Medical, Surgical, Radiological Cardiology or Other Procedures (eg. HIV Test Consent)
Consent to Procedure
- Cardiac Catheterization Laboratory Patient History & Physical
- Cardiac Catheterization Laboratory Nursing Flow Sheet
- Cardiac Catheterization Report
- Anesthesia Record (blue and yellow striped border)
- Operative Note (grey) (typewritten)
- Burn Unit Operative Report (Anterior/Posterior View)
- Ophthalmic Surgery Sheet (typed report on blue paper)
- Colonoscopy Report
- Endoscopy Record (Physicians)
- Endoscopy Record (Nurses)
- Fiberoptic Esophagastroduodenoscopy Report
- Specific Endoscopy Report
- Pathological Specimen Report
- Operations Record
- Intraoperative Nurses’ Note/Perioperative Nursing Record (yellow)
- Implant Sheet
- Recovery Room Record (pink with red border) and/or Cardiopulmonary Bypass Record (blue & white)
- Thoracic Intensive Care Unit Post-Operative Admission Assessment

Consultation or Refer Sheet
Consultation/Refer Response (file the response behind consult or Refer

Physical Therapy Initial Evaluation
Physical Therapy Final Summary
Physical Therapy Progress Notes
Occupational Therapy (purple border)
Continuing Patient Care Form
Physician’s Plan of Treatment and/or
Nursing Record and Care Plan

Reports in Date Order
Closed Medical/Surgical Record Order

- Radiation Therapy Consultation Request (yellow)
- Blood Bank Transfusion Reaction Consultation Request and Report Consultation Report, Department of Radiology (pink)
- Blood Transfusion Record Form
- Laboratory Reports (blue border)
  - ligand assay laboratory (shingle)
  - hematopathology (blood and urine) (shingle)
- Cumulative Summary Report Department of Pathology
  - yellow (temporary)
  - green (temporary)
  - pink (permanently replaces temporary copies)
- Laboratory Flow Sheet
- Inhalation Therapy Sheet (shingles)
- Respiratory Therapy Ventilators Requisition and Case Record
- Respiratory Therapy Progress Notes (Respiratory Care Chart Report)
- Respiratory Therapy Patient Record

EKG
- 2-D Echocardiogram
- Pulmonary Function-Arterial Blood Gases Report and Interpretation
- Plasma Catecholamine Report
- Serum Immunofixation
- Drug Study
- Hemodynamic Profile
- Hemodynamic/Metabolic Report
- Urea Generation/Nitrogen Balance
- Physical Therapy Progress Notes
- Neurovascular Evaluation
- Occupational Therapy (purple)
- Electroacoustic Impedance Measurements (red and blue striped border)
- Hearing Aid Evaluation (red and blue striped border)
- Audiogram (red and blue striped border)
- Audiological Evaluation (red and blue striped border without referral)
- Polysomnographic Report (Sleep Study)
- Electroencephalographic data sheet
- Gynecology Ultrasound
- Nuclear Medicine Patient Status Report (yellow or white)
- Social Work Report (purple border)
- Newborn Maturity Rating and Classification

- Consent to Anesthesia
- Preoperative/Postoperative Outpatient/ADP Record (if patient is admitted after outpatient surgery)
- O.R. Check List
- Radiology Dept. Post-Procedure Continuation Notes (Nursing Flow Sheet)
- Oxygen Delivery and Utilization/Transfusion Data, & Lab Data Flow Sheet
- Thoracic Intensive Care Unit Post-Operative Admission Assessment
- Patient Charge Items
- Inpatient Evaluation for Therapeutic Bed
- SoftCare Mattress Evaluation
- Central Sterile Supply Discharge supply form (if no surgery performed, then place on top of physicians orders)
- Certification of Physician Services
- OB/GYN Lab Order Sheet
Closed Medical/Surgical Record Order

Clinical Pathology Laboratory Requisition and Physician Order Form (purple, green, gold)
Anatomic Pathology Laboratory Consultation Requisition and Physician Order Form (white with red border)
(pink with red border)
Radiology Procedure Order Form (white with blue) (3 sections)
Admitting Physician Order Sheet
Preadmission Orders
Physician's Orders (white with blue)
Parenteral Nutrition Order and Administration Form

Physician Medication Order Renewal Form
Hyperalimentation Order Form
Pediatric Parenteral Nutrition Order Form
Patient Controlled Analgesia & Episural Opiate Record
Medication Administration Record
Medication Record, I.V. fluids and I.V. additives (pink)
Recurrent Medication Record (blue)
Non-recurrent Medication Record (green)
Final Discharge Medication Profile or Summary
Antiepileptic Drug Level Flow Sheet
24 Hour Medication Titration Record
Medication Titration Flow Sheet (yellow)
Emergency Drugs (Mott Hospital)
"Code" Record

Nursing Problem List (blue)
Pediatric Surgery Assessment
Patient Education Record (blue or white)
Nursing Progress Notes (blue)
ADL, Treatments, Clinical Parameters (blue)

Flow Sheet
Intra-aortic Balloon Pump Flow Sheet
Peritoneal Dialysis Flow Sheet
Vital Sign Record
Supplementary Graphic Sheet
Cardiopulmonary Resuscitation Flow Sheet
Pediatric 24-hour Patient Care Summary
Pediatric Urology Genitourinary Myelomeningiocele Flow Chart
24-Hour Patient Care Summary
Patient Care Plan (Hemodialysis form)
Diabetic Record
Diet Plan Record
Diabetes Monitoring Record

01/29/90
(m&ssrec)
ORDER OF ASSEMBLY OF
THE INPATIENT MEDICAL RECORD

Each category is to be placed in chronological order from Admission (on top) through discharge (on bottom).

Hypersensitivities Sheet

**INPATIENT NOTES DIVIDER**
- Face Sheet
- Survival Flight Notes
- Emergency Room Notes
- Preadmission continued Review Form
- Concurrent Coding Documents
- Nursing Admission and Discharge Planning
- Nursing Admission Assessment
- Nursing Care Plan
- Inpatient Notes
- Discharge Note/Follow-up Orders Form

Any forms printed on Inpatient Notes are placed in chronological order in the Inpatient Notes, as close to the date as possible.

Any report typed on a self-adhesive label is placed on an Inpatient Note, as close to the date as possible.

Any nursing form printed on yellow paper, i.e. Nursing Admission Assessment, is placed in chronological order in the Inpatient Notes.

Any OR/ADP form printed on yellow paper is placed in chronological order in Inpatient Notes.

**DISCHARGE PLANNING DIVIDER**
- Nursing Discharge Planning Guide
- Nursing Discharge Summary
- Nursing Discharge Summary - Continuation
- Nursing Transfer Summary

**CONSULTATION SHEET DIVIDER**
- Consultation/Referral sheets

Reports (sigmoidoscopies, gastroscopies, etc.) or Progress Notes (i.e., P.T. or O.T.) based on initial Consultation or Refer Sheets are to be filed immediately behind the Consultation or Refer Sheet requesting them (i.e., a sigmoidoscopy report is filed immediately behind the Consultation or Refer Sheet requesting it).

Should a biopsy be done, however, the resulting Pathology Report is filed under the Special Tests and Procedures divider, as is the permit (Consent) form related to that procedure.

Reports not accompanied by initial Consultation or Refer Sheets may be filed by category under the Special Tests and Procedures divider.

**X-RAY REPORTS DIVIDER**
- Pink Radiology Reports only (refer to date of film not dictation)

**LABORATORY REPORT DIVIDER**
- Laboratory Flow Sheet
- Temporary Lab (Green)
- Permanent Lab (Yellow)
- Discharge Summary (Pink)
- Blood Bank Transfusion Record
- Arterial Blood Gas Report and Interpretation Form

**SPECIAL TESTS AND PROCEDURES DIVIDER**
- Special Reports - i.e., Respiratory Therapy Patient Record, Respiratory Therapy Progress Notes, Nuclear Medicine Test Reports (yellow), Audio Test, etc. File like reports together in chronological order.
- ADTU procedures are also filed here. They usually include the consent Form, ADTU Record, Patient Charge Items, ADTU Report and Pathology Report. File each procedure as a separate unit on this order.
EKG DIVIDER

EKG Reports
*(Note - EKG permanent reports are black-white print. The temporary report, red and white print is discarded, except in some ICU's, when the permanent copy is filed on the chart.)*

O.R. PROCEDURES DIVIDER

Operative Forms - Each O.R./ADP Procedure is to be filed in the following order as a separate unit:
1. Operative Permit
2. Anesthesia Permit
3. O.R./ADP Checklist
4. Anesthesia Record
5. O.R. Record (white)
6. Operative Report (grey)
7. Recovery Room (PARU) Record (pink)
8. Patient Charge Items - O.R.
9. Patient Charge Items - Recovery Room
10. Pathology Report

- Soft Care Evaluation Form
- Therapeutic Bed Evaluation Form

PHYSICIAN ORDER DIVIDER

Admitting Physician Order Sheet
Admission/Service Change Order Sheet
Order Sheets

TPN/LAB REQUISITION DIVIDER

TPN Order Sheets
Enteral Nutrition Orders
Lab Requisition Originals

DIAGNOSTIC ORDER DIVIDER

Diagnostic Order Sheets

NURSING FORMS DIVIDER (blue forms)

- Medication Titration Flow Sheet
- PCA Flow Sheet (If not kept on bedside)
  Problem List
  Patient Education Record (If not kept on bedside)
  24 Patient Care Summary Sheets (used in ICUs)
  Peritoneal Dialysis Record
  Hemodialysis Record
  Diabetic Record
  Dietetics Records
  Cardiac Flow Sheet

OUTPATIENT/OUTSIDE REPORTS DIVIDER

Outside Correspondence

BEDSIDE CHART

Hypersensitivities Sheet
PCA Flow Sheet
Recurrent Medication Record (blue)
Non-Recurrent Medication Record (green)
IV Fluid Medication Record (pink)
Patient Education Record
ADLs
Flow Sheet (TPR)
APPENDIX IV

Medical Supply Companies-Consultation About Medical Record Design

Physicians Record Company
Chicago, IL

Record Programs
Chicago, IL

AFV Filing Systems
Chicago, IL

Markley Filing Supplies
Chicago, IL

AccuFile
Minneapolis, MN

Remco
Southfield, MI