Chart Manager Orientation Manual

Introduction

Welcome to the Medical Records Department. You will be stationed on the inpatient floors and are a vital part of the department. We hope your time with us will be beneficial and rewarding.

The purpose of the Chart Manager position is to facilitate the completion of the medical record during the patient’s stay in-house. The Chart Managers will provide coverage on inpatient floors 7 days a week working the core hours of 6 am to 2:30 pm. This is a brand new approach to the completion of the medical record. We think this will be an exciting project and we will be available to assist you anyway possible. However, this process will depend on you. Remember you are a direct representative of our department.

In an attempt to aid you in your daily activities, we have designed this manual. Please familiarize yourself with this manual.

CONCURRENT CHART COMPLETION PROJECT

WHAT: The Staff from Medical Records who have assembled charts after patient discharge will now be assigned to patient care areas to assist in the completion of the charts on a daily basis. These people will be called chart managers.

WHY: It now takes almost 3 weeks from time of discharge to assembly and analysis of the patient’s chart after discharge. JCAHO allows only 4 weeks from discharge for the entire completion including physician completion of the record. We need to get the chart to the physician within 1 week of discharge.

GOAL: To have a completed patient record by the time the patient is discharged.

HOW: There will be a consistent person assigned to one or two patient care divisions. They will work 6AM to 230PM, Monday through Friday. Weekends will be covered for pickup of patient discharge charts once all areas are staffed.

Primary responsibilities: Check charts daily for accurate filing, identification of forms, proper location of forms, check for unsigned orders and follow-up, thin too thick charts and prepare for volumes, track transferred patient’s old charts, assign physician deficiencies in the SoftMed System, communicate with clerical/nursing staff re issues with chart completion.

What it isn’t: An additional patient clerical staff to answer phones directs visitors, process orders, stuff charts, etc. Although these staff will be of assistance to the clerical staff in the process of getting charts properly assembled, broken down after discharge and tracked on the units.

What you can do to help: Communicate with this “chart manager” re unsigned orders, lack of reports in a timely manner, missing parts of patient’s charts on transfer from ICU, OR, etc. Be open to their presence on the patient care units and share space with them. Communicate questions/concerns/benefits to their manager: Margaret Henderson at 3-6624 or to your Clinical Nurse Manager. Give your suggestions for how to make it work better. Give it time to work.

Thank you.
WORK ETHIC EXPECTATIONS

1. WEEKDAY SCHEDULING AND COVERAGE:

The Medical Records Department follows the University policies for attendance. Criteria have been established for tardiness, shift trading and unauthorized absences.

a. Work Schedules:

The inpatient units will be covered 7 days a week. Monday through Friday the Chart Managers will work 6 am to 2:30 pm to be on units when physicians are rounding. On the weekends, the Chart Managers will work only on discharged patient charts from all floors and hours may vary. Scheduled leave days such as vacation leave or sick leave need to be requested 4 weeks in advance. The supervisor of the Files Section will be responsible for scheduling the relief clerks to cover for your vacations. A supervisor must first approve all employee changes in schedule. Due to time constraints, all employees time must be reported to payroll, by the supervisors, no later than 10:00 am on the Monday prior to payday.

b. Arriving to Work:

Each employee is expected to report to work on time. Any tardiness will be documented and deducted from the time card. *Excessive tardiness will be grounds for disciplinary action and eventual termination. If an employee expects to be late, he or she must call and report this possibility to the supervisor. Unusual circumstances will be considered, however, generally the guidelines for tardiness will be as follows; 3 occasions will warrant a verbal warning, the 4th occasion will warrant a written warning, and the 5th occasion could result in probation, 6th occasion suspension without pay, 7th occasion 3 day suspension, 8th occasion could result in termination. The time frame for disciplinary action will be a 6-month period.

For payroll purposes only, arrival of staff will be recorded on the basis of 15-minute periods. For example, arrival on the 8th minute will be considered being 15 minutes late.

c. Breaks:

Each employee is entitled to two 15 minute breaks and an hour for lunch during their shift.

2. WEEKEND SCHEDULING:

The Chart Managers will rotate weekends among the staff, both Saturday and Sunday. It should be noted that if it is your Saturday/Sunday to work and you are ill, you would be responsible for calling the other Chart Managers to arrange coverage for your shift. Also, you will be expected to work an additional weekend to make up for the one you missed the next schedule.

3. EMPLOYEES CALLING IN:

The employee who is ill and/or expects to be absent must call his/her supervisor at least an hour before the shift begins so that coverage can be arranged.

4. UNSCHEDULED ABSENCES:

a. New Employees:

(1) The first absence during the new employee’s probation period will result in a one-month extension of probation.

(2) The second absence will result in a three-month extension of probation and must be supported by a physician’s statement.

(3) The third absence will result in the employee failing to pass probation, in other words, termination.
b. **Full-time Staff:**

See Hospital Policy, 09-23

5. **HOLIDAYS:**

Holidays will be rotated and will be treated as a Saturday or Sunday (your goal on these days will be to assemble and analyze discharged patient’s charts). Holidays are defined as:

New Year’s Day  
Martin Luther King, Jr.  
Memorial Day  
July 4th  
Labor Day  
Thanksgiving  
Christmas  
Election Day - every 4th year for Presidential Election

6. **APPEARANCE AND BEHAVIOR:**

a. Each employee is expected to conduct him or herself in a professional manner. Hospital policies for appearance and behavior must be followed.

b. The Chart Manager will serve as a resource for many people seeking information, as you will be seated with the Nursing Clerical Services person. The refusal to assist or refer someone is unacceptable. An, “I don’t know” response to any type of question is also unacceptable. It will be the Chart Manager’s responsibility to guide the questioning person in the right direction to achieve the answer that is being sought. While your role is to maintain the medical record, because you will be visible, you will attract many different types of questions. Each person should be responded to in the following manner:

(1) Face the requester, give eye contact, be pleasant and respond in a way that relays an attitude of helpfulness. “May I help you?” is appropriate.

(2) Indicate verbally that you have heard the request.

(3) If you are unable to help someone, assist him or her in finding someone who can.

c. Remember, because you are in a location that is visible to all, interruptions will happen and it will be up to you to steer the requesters in the correct direction always keeping in mind that you are on the floor for chart completion.

7. **CONFIDENTIALITY:**

Patient information is not to be discussed except as it pertains to your job.

8. **IMAGE:**

Chart Managers are expected to adhere to the departmental dress code.

9. **ID BADGES:**

Must be worn at all times on your upper torso so that everyone will know to whom they are speaking.
CONCURRENT ANALYSIS PROCEDURES

1. DEATH CHARTS:
   a. Death Charts will be forwarded to admitting by the clerical staff in the blue binders
   b. Admitting will determine if they need the chart or others such as pathology, coroners, etc. and they will forward the chart to appropriate location
   c. If chart is not needed in the above mentioned locations, the chart will be returned to inpatient floor from which it came.
   d. Chart Manager will complete chart and deliver to Medical Records
   e. If chart goes to pathology, the Admitting clerk will notify supervisor that the chart was sent to pathology and the Supervisor will forward that information via E-mail to the Chart Manager. We will leave the chart for 3 days before perusing by calling 3-5425 and asking for Karen.

2. VOLUMES AND THINING OF INPATIENT RECORDS:
   a. Thinnings:
      When a patient’s chart becomes too thick to remain in the original blue binder, the Chart Manager or Patient Clerical/Nursing staff will thin the record only moving items listed below to the 3 inch RED binder and affix the patient’s name and hospital number on outside of record.
      Thin only:
      (1) Physician orders
      (2) EKG and other special tests
      (3) Radiology
      (4) Laboratory
      (5) Respirator
      (6) Medication sheets
      (7) Graphics
      (8) Nursing notes
   b. Volumes:
      When a patient’s blue binder becomes 2.5 inches thick; you will make another volume. When it becomes time to remove the chart from the blue binder and place it in its original chart and that record is too thick, you will need to request a volume. Using the PM system you will request a volume as follows:
      (1) Sign on in PM in the normal fashion
      (2) Choose MPAC
      (3) Choose CLIN
      (4) Type MEDR
      (5) Press enter
      (6) Using the mouse select volume change request
      (Note a form will appear on the screen. Fill form out. See example next page).
3. **REQUESTING CHARTS AND TEMPORARY CHARTS:**

a. **Requesting Charts:** If you did not receive a chart to file the most recent discharge in, request chart over clinipac printer. To request a chart use the PM System by following the procedure listed below:

1. Type MPAC
2. Type CLIN
3. Type MEDR
4. Enter
5. Using the mouse, choose MR request
6. Fill in request

(Note: See example on previous page with request for a volume. You can request up to three charts on one request).

b. **Temporary Charts:** If the chart cannot be found, make a temp chart. To make a temp chart:

1. use prenumbered charts and roll of numbers to make the chart folder you need
2. In pencil write all information on chart; patient’s name, hospital number across top, down the side and the back of chart, write on front of chart T1 indicating that this is a Temp chart. **DO NOT MAKE A BARCODE FOR TEMP CHARTS.**
3. Process the same as all other records

4. **DISCHARGED CHARTS, MISROUTED FILING, AND ADD-ON DISCHARGE CHARTS:**

a. **Discharged Charts:**

The Chart Manager will report to the Medical Records Dept. at the beginning of their shift and at the end of the shift. At 6 am each morning, all discharge records from the previous day will be pulled and ready to be taken to the floor. The Chart Manager will charge the records to the area to which they are taken.

b. **Add on Discharge Charts:**

1. In the event of add-on discharges, the Chart Manager will use Clinipac to request charts from the Files Section. The Files Section will deliver these charts to the floor.

2. The Chart Manager should charge charts to Medical Records and bring them down at least twice a shift.

3. When charts are brought into the department, the Chart Manager should file them in the appropriate location.

c. **Misrouted Filing:**

Occasionally, the Medical Records Dept. will receive filing for inpatients. When this happens, the filing will be routed to the appropriate File clerk. The File Clerk will determine which floor the filing has come from and place filing in predesignated area for Chart Manager to retrieve. The Chart Manager will take filing to floor and file in patient’s chart.

5. **INCOMPLETE CHARTS ON THE FLOOR:**

It will be the responsibility of the Chart Managers to pay attention to all charts that are already on the floor. You will need to determine how long a chart has been on the floor by looking in SoftMed to see when the chart was logged to the floor. If incomplete charts are found on the floor, they
6. **COMMUNICATION**: 

All Chart Managers will be on E-mail to facilitate communication between the Chart Managers and the Medical Record Department Supervisors.

7. **SUPPLIES NEEDED**: 

After a meeting with staff in each area, space for storing supplies will be assigned. The following supplies will be needed:

   a. Tacky Finger
   b. Pens
   c. Whiteout
   d. Chart flags; all colors
   e. Pinks
   f. Progress notes
   g. Charts
   h. Roll of numbers
   i. Hole punches
   j. Permaclips
   k. Ruler
   l. DNR stickers
   m. Yellow dividers
   n. Blue dividers
   o. Green dividers

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**ANALYZING INSTRUCTIONS**

**REGULAR CHARTS**: 

1. The discharging resident dictates discharge Summary.

2. Must have daily note from service of which the patient is admitted or transferred. Can be written by resident or attending. If you need a daily note written, ask a resident to write you’re not except in neonatal charts.

3. The attending physician must co-sign or write one daily note each day of the admission except for the first day.

4. Pre-anesthesia notes (blue sheet) must be completed and co-signed by the anesthesia attending or the attending may write their own note on the back of the blue sheet.

5. Post-anesthesia record must be completed on the back of the blue sheet if there is no post-anesthesia not on the back of the Operative Note/Histopathology Report.

6. The general anesthesia record must be signed by the anesthesia attending.

7. The attending physician must sign operative procedure notes.

8. The attending physician and the anesthesia attending must sign Operating Room Patient Record.

9. Post-anesthesia note must be completed and signed by the anesthesia attending or resident.

10. Operative Report is usually dictated by the resident, but must be signed by the attending.

11. All physician order must be signed. If you can’t read the signature or it contains no beeper number give it to the attending physician to sign.

12. A resident or an attending must cosign all student and acting interns (AI) progress notes, physician orders, etc.
13. All Nurse Practitioners, ARNP’s, PA’s and midwife notes do not need cosigning except if you need an attending for that day.

**OB CHARTS:**

1. Discharge Summary will not have to be dictated if the admission is a normal delivery with no complication and the record is accompanied with a completed OB Discharge Summary Form in the chart or it is blank; the resident on the case will be asked to dictate. A normal stay is usually 5 days or less. C-sections, tubals, and OB undelivered must have a dictated discharge summary.

2. OB Summary Sheet must be completed and signed. The discharging attending must co-sign this form.

3. Daily notes must be written and an attending must co-sign all daily notes. When needing daily notes co-signed use the OB Schedule. Your L&D physician will be the physician who needs to co-sign your notes.

4. OR Section needs to be analyzed the same as regular charts.

5. All physician orders must be signed.

**NEWBORN CHARTS:**

1. Discharge summary for routine newborn stays (less than 5 days) with no complications does not need to be dictated.

2. Newborn Progress Notes/Discharge Assessment Sheet must be completed and the attending must co-sign it.

3. Daily notes-the only progress note that is required is a circumcision note if the infant is a boy.

4. The Newborn Summary Sheet is signed by the attending and is therefore considered an attending note.

5. All physician orders must be signed.

**NEONATAL CHARTS:**

1. Discharge Summary must be dictated.

2. Daily notes must be written everyday of the admission, if a note is not written ask the attending to write the missing note.

3. An attending must co-sign or write a note for each day of the admission except for the first day.

4. OR section is analyzed the same as for regular charts.

5. All physician orders must be signed.

**OBSERVATION CHARTS:**

Discharge Summary must be dictated.

**OUTPATIENT SURGERY CHARTS:**

1. OR section must be completed.

2. The resident must dictate operative report or attending if no resident listed.