UCONN HEALTH

UCONN JOHN DEMPSEY HOSPITAL

SECTION: RECORDS MANAGEMENT NUMBER: 12-018

SUBJECT: DOCUMENTATION REQUIREMENTS FOR ALL PROCEDURES PAGE: 1 OF 2

PURPOSE:

To ensure that the medical record thoroughly documents operative or other procedures.

POLICY:

CONSENT

1. Informed consent for procedures and operations will be obtained as per policy (See: Informed Consent, Clinical – Obtaining and Documenting; https://health.uconn.edu/policies/wp-content/uploads/sites/28/2021/02/Informed-Consent-Clinical-Obtaining-and-Documenting.pdf)
   and documented within the medical record.

DOCUMENTATION

2. A complete history and physical examination shall in all cases be documented for every patient having surgery or a procedure requiring conscious sedation or general anesthesia:
   A. For inpatients: documentation should be no more than thirty (30) days prior to or within twenty-four (24) hours after admission
   B. For outpatients: documentation should be no more than thirty (30) days prior to registration.
   C. For a history and physical less than thirty (30) days old, a note documenting that the history and physical has been reviewed, and documenting any salient changes in the patient's condition shall be written by the surgeon/proceduralist prior to the surgery/procedure.

3. An operative report shall be written or dictated by the physician immediately following surgery or a high-risk procedure. The operative/procedure note shall include:
   A. Date of Operation
   B. Patient Name
   C. Medical Record Number
   D. Pre-Operative Diagnosis/Indication
   E. Post-Operative Diagnosis/Findings
   F. Procedure Performed
   G. Complications if any
   H. Description of Procedure

UCONN HEALTH

UCONN JOHN DEMPSEY HOSPITAL

I. Description of Findings
J. Specimens Removed
K. Anesthesia Used
L. Estimated blood loss
M. Name of Primary Surgeon or Proceduralist and any Assistants
N. Patient Status at End of Procedure/Disposition

4. If a full operative/procedure note is not immediately documented, then an immediate post-operative progress note (Brief Op Note) should be documented in the medical record following surgery. This note should include:

   A. Name of the primary surgeon(s) and any assistants
   B. Procedure performed
   C. Description of the procedure and the findings
   D. Estimated blood loss
   E. Specimens obtained
   F. Pre-op and post-op diagnoses

5. The operative/procedure report must be authenticated by the surgeon and filed in the medical record as soon as possible after surgery and as per HAM policy 12-024 COMPLETION OF MEDICAL RECORDS, DELINQUENT MEDICAL RECORDS, SUSPENSION OF PRIVILEGES.

6. Procedures that do not require a dictated or written procedure note include:
   A. Peripheral Venous Puncture
   B. Arterial Blood Gas Puncture
   C. Foley Catheter
   D. Nasal Gastric Tube
   E. Rectal Tube
   F. Peripheral Intravenous Catheter

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