Rancho Los Amigos National Rehabilitation Center
HEALTH INFORMATION MANAGEMENT
ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT:	**MEDICAL RECORDS DOCUMENTATION STANDARDS**	**Policy No.:**	**A326**
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PURPOSE:

To communicate DHS medical records documentation standards and requirements as delineated in DHS Policy No. 390.1

RATIONALE:

Documentation problems have a cumulative impact, which involves increasing financial loss to the County, decreasing public trust, and the appearance of poor-quality care. In order to address these issues, the Department of Health Services developed standards to set system-wide expectations for documenting the care provided. All DHS employees who document in a patient's medical record are provided with a copy of these standards and are evaluated for their compliance with these standards.

GUIDELINES:

1. Definitions
    - 1.0.1 Medical Record: The legal document that records information regarding a patient's care and treatment at a DHS facility.
    - 1.0.2 Provider: The person who provides that care can be a physician, nurse, technician, allied health professional, etc.
    - 1.0.3 Documentation: The information placed in the medical record that provides a description of the care provided, the patient's response to that care, the medical impressions about that care, and the recording of laboratory or diagnostic test results. Also included are flow sheet recordings of vital signs, etc.
    - 1.0.4 Legible: The information must be readable.

1.1 Purpose of documentation

- 1.1.1 To create a record and document a patient's complaints, history, findings, impressions, diagnosis, treatments, and outcomes.
- 1.1.2 To provide a means of communication between various providers about the patient's condition.
- 1.1.3 To record diagnoses and procedures to justify third party reimbursement.
- 1.1.4 To serve as a legal document to provide evidence of care rendered in the event of a legal dispute.

1.2 Information to documentation

DHS's electronic medical record system (ORCHID) helps provide general compliance to basic documentation guidelines. Whether in electronic or in cases where paper documentation is still used (e.g., downtime forms, wound staging photos, etc.) the general rules below applies:

1.2.1 General rules

1.2.1.1 The patient's full name and medical record number must be on each page.
1.2.1.2 Dates, times, signatures and titles are required for each entry.
1.2.1.3 Signatures must identify the signee by either being legible or by having the signee print his/her name below the signature.
1.2.1.4 Handwritten entries must be legible.
1.2.1.5 Handwritten entries must be made in black font color or ink.
1.2.1.6 Corrections may be denoted by the strikethrough entry:
a) For electronic documentation, add and sign addendum.
b) For paper documentation, add initials above the line, followed by the date and time. Then write above the correction in the margin next to the correction reason for the change.
1.2.1.7 NO WHITE OUT OR ANY OTHER OBLITERATION IS ALLOWED.
1.2.1.8 Entries must correspond in time to the care provided.
1.2.1.9 Late entries (notes recorded that are out of time sequence with prior existing notes) are acceptable only if the information is designated as a "late entry" and the note identifies the date and time it was actually written.
1.2.1.10 Subsequent notes (notes used to document information that occurred previously, but do not qualify as a late entry) may be made if the information is required to clarify or correct previously written information. Subsequent notes must identify the date and time actually written and make reference to the date and time of the prior note which is being clarified.

1.2.2 Consistency

1.2.2.1 Information recorded in the medical record must be accurate and factual and support conclusions and impressions. (e.g., if the provider documents a "delay in care", the note should include a depiction of critical times instead of just recording "delay")
1.2.2.2 The provider must review previous notes by other providers at the time of documenting a progress note. This will ensure continuity and consistency in the record.
1.2.2.3 The provider must review and correct dictated notes, which may include procedure and/or operative notes, prior to signing them.

1.2.3 Documenting Complications and/or Adverse Events

1.2.3.1 Documentation of complications/adverse events must be objective, factual, accurate, and timely.
1.2.3.2 Documentation should note that the patient and/or family was informed of the complication/adverse event, when possible. If not informed, the reason should be noted.
1.2.3.3 Documentation following a complication/adverse event must include the plan for continuing care.
1.2.3.4 For complications/adverse events that involve a specific health care team, all members of that team should have access to the same set of facts concerning times and sequences of events. Clarify factual details and sequences, if needed. Inconsistencies should be avoided, if possible.

1.2.4 Documenting Disagreements

1.2.4.1 The medical record is not to be used to express negative comments about medical care rendered by another provider.

1.2.4.2 Disagreements between providers related to findings of exams or interpretation of diagnostic tests should be noted and resolved, if possible.

1.2.4.3 Disagreements between providers on the treatment plan shall include the basis for any alternative treatment recommendations.

1.3 Review and Compliance with Documentation Standards

1.3.1 The attending physician shall be responsible for ensuring compliance with these standards during his/her tour of duty.

1.3.2 The chief of service shall be responsible for ensuring compliance with these standards within his/her division.

1.3.3 The Medical Director/Chief of Staff shall be responsible for ensuring compliance with these standards within his/her facility.

1.3.4 These documentation standards shall be included in the departments' quality review/clinical pertinence evaluations.

1.3.5 Review of the adequacy of documentation and an evaluation for any inconsistencies in documentation shall be a part of every sentinel event/critical clinical event review.

1.3.6 If a review determines a need for education or other remediation related to documentation, this education or remediation shall occur and be documented as part of the departments peer review/performance review process.