COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: MEDICAL RECORD DOCUMENTATION BY MEDICAL STAFF **POLICY NO. 605B**

PURPOSE:
This policy describes the requirements for medical record documentation by attending physician staff at Harbor-UCLA Medical Center.

POLICY:
Attending physicians must complete the required elements of documentation in the medical record in a timely fashion.

PROCEDURE:
ADMISSION HISTORY & PHYSICALS (H&Ps): The Admission H&P will be completed within 24 hours after admission. The Attending Physician who supervises the admission must sign the resident H&P within 24 hours of it being forwarded to him/her for review or document his/her own H&P separately. The Attending Physician will ensure that the H&P is complete, including a history of present illness, vital signs and examination of the heart, lungs, and organ system(s) relative to the chief complaint, and assessment and plan (See Policy 608).

INITIAL CONSULTATION NOTES: Inpatient consultation notes must be signed by the attending physician from the consulting service within 24 hours, seven days a week. The 24-hour requirement begins at the time that the consultation note is forwarded to the attending physician for review (See Policy 360A).

INPATIENT PROGRESS NOTES AND ONGOING CONSULTATION NOTES: The responsible attending physician will sign the daily progress notes for all inpatients within 24 hours of the time it is forwarded for signature. Alternatively, the attending can write their own progress note daily for patients.

EMERGENCY DEPARTMENT / URGENT CARE NOTES: The attending physician or supervisory resident will review and sign the patient's record within 24 hours of evaluation and, at that time, ensure that the supervision of the resident or allied health provider is documented in the record. If the supervisory

EFFECTIVE DATE: 07/2017 **SUPERSEDES:**
REVISED:
REVIEWED: 07/2017
REVIEWED COMMITTEE: Professional Staff Association Review Committee

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Patricia Soltero Sanchez, RN, BSN, MAOM
Chief Nursing Officer

Signature(s) on File.

resident is the first to review the record, the Emergency Department or Urgent Care attending physician responsible for the care of the patient will review and sign the patient's record, or write a separate note, within 72 hours of the patient record being forwarded to him/her for review.

OUTPATIENT CLINIC NOTES: Outpatient clinic notes will be completed in the medical record within 24 hours of the patient's evaluation. The attending physician responsible for the care of a patient in the outpatient clinic will sign all clinic notes within 72 hours of the note being forwarded to him/her for review. Alternatively, the attending can write a separate note documenting their evaluation of the patient in clinic, but this also will be completed within 72 hours.

PROCEDURE NOTES: When an operative or other high-risk (i.e., requiring the use of moderate or deep sedation) procedure is performed, the procedure note will be dictated or entered into the medical record within 24 hours of the procedure. The attending physician responsible for supervising the procedure will sign the note within 24 hours of the note being forwarded to him/her for review. The attending physician will ensure that the procedure note contains the necessary elements and that, when appropriate, a pre- and post-anesthesia evaluation is documented.

DISCHARGE SUMMARIES: A discharge summary should be completed immediately following the discharge or death of a patient, if not before, and always must be completed within 24 hours. The supervisory resident (See Policy 622A) will sign the discharge summary within 72 hours of the note being forwarded. If the supervisory resident is not available to sign the discharge summary, then the attending physician responsible for the patient at the time of discharge will be responsible for signing the discharge summary within 72 hours of the note being forwarded for him/her to review.

Reviewed and approved by:
Medical Executive Committee on date 07/24/2017

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Brant Putnam, M.D.
President, Professional Staff Association

Signature(s) on File.

APPENDIX A:

	Time to initial completion in record	Document attending supervision	Forward for signature of	Time to sign by attending
Admission H&P	Within 24 hours	Yes	Attending	Within 24 hours of the time of forward for signature
Initial Consultation Note	Within 24 hours	Yes	Attending	Within 24 hours of the time of forward for signature
Inpatient Progress Note or Ongoing Consultation Note	Within 24 hours	Yes	Attending	At a minimum of every 24 hours for ICU and every 48 hours for non-ICU
ED/UCC Note	Within 24 hours	Yes	Supervisory resident or attending	Within 24 hours of forward from initial resident or within 72 hours of forward from supervisory resident
Outpatient Clinic Note	Within 24 hours	Yes	Attending	Within 72 hours of the time of forward for signature
Procedure/Operative Note	Within 24 hours	Yes	Attending	Within 24 hours of the time of forward/ available for signature
Discharge Summary	Within 24 hours	Yes	Supervisory resident or attending	Within 72 hours of the time of forward for signature