LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: MEDICAL RECORD DOCUMENTATION **POLICY NO.** 605

CATEGORY: Health Information Management	**EFFECTIVE DATE:** 12/78
POLICY CONTACT: Charles Onunkwo	**UPDATE/REVISION DATE:** 1/23
REVIEWED BY COMMITTEE(S):	

PURPOSE:
This policy describes the requirements for medical record documentation by attending physician staff at Harbor-UCLA Medical Center, provides guidelines for writing daily progress notes and data elements that reflect patient care, and provides guidelines for correcting errors in the Electronic Health Record (EHR).

POLICY:
Attending physicians must complete the required elements of documentation in the medical record in a timely fashion. Harbor-UCLA Medical Center shall update the Progress Notes to facilitate continuity in patient care and to serve as a legal record. All notes and corrections to the EHR are consistent with good medical practice and are made by the provider who documented the original notes.

PROCEDURE:

I. CONTENT

A. The Progress Note should clearly reflect:
- The patient's clinical condition
- What is being done in terms of diagnostic and therapeutic measures
- The patient's response to treatment provided
- Reassessments
- Documentation of any adverse drug or transfusion reactions
- Documentation of the ongoing involvement of the Physician of Record in the care of the patient

Note: "Status Quo" and "doing well -- no change" should never be used.

B. Providers must electronically sign each entry.

II. TIMELINESS

A. 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

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APPROVED BY:

Anish Mahajan Digitally signed by Anish Mahajan Date: 2023.03.07 12:27:36 -08'00'
Anish Mahajan, MD
Chief Executive Officer
Chief Medical Officer

Griselda Gutierrez, MD Digitally signed by Griselda Gutierrez, MD Date: 2023.03.06 17:29:57 -08'00'
Griselda Gutierrez, MD
Associate Chief Medical Officer

Jason Black Digitally signed by Jason Black Date: 2023.03.06 13:56:53 -08'00'
Jason Black, MBA, DNP, RN
Chief Nursing Officer

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).

B. 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).

C. 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 each note is forwarded for signature. Alternatively, the attending can write their own progress note daily for patients.

1. The Progress Note must be written on a daily basis.
   Exception: In the Department of Psychiatry, a team Progress Note is written daily and a Provider Progress Note is written a minimum of five (5) times per week.

2. The admission history and physical (H&P) may serve as the first Progress Note.

3. A Progress Note on the last day of hospitalization is not required if the patient's status is clearly indicated on the Discharge Summary or the downtime Physician Discharge Report (HH 295) form.

4. The Attending Physician shall evaluate the patient at least every two (2) days, and every day if the patient is in the Intensive Care Unit or as required by external agencies. A Progress Note written by a Resident Physician or Physician Assistant must include in the Progress Note that s/he has discussed the case with the Attending Physician, or the Attending Physician shall record and sign his/her own note. A Progress Note written by Advanced Practice Nurses should include documentation of discussion with Attending Physician only if required by policy or procedure.

D. 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 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.

E. 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.

1. The Progress Note must be written for each patient visit.
2. The Progress Note should reflect the following for each visit:
3. Chief complaint or purpose of visit
   - Patient's present condition
   - Whether patient's condition has changed from the previous visit or hospital discharge

- Objective findings
- Diagnosis or medical impression
- Studies ordered, such as laboratory or x-ray studies
- Medications and therapies administered
- Disposition, recommendations and instructions to the patient

F. 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.

G. 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.

H. ANCILLARY CONSULTATIONS: Consultation notes and recommendations for patient care from ancillary services, including but not limited to Nutrition and Wound Care Services, will be forwarded to the attending of record for review and approval. The attending's signature on these consultation notes is acknowledgement and concurrence of the recommendations for patient care. If the attendings evaluation, opinion, or recommendations differ from the ancillary consultation recommendations, the attending shall place an addendum on this note to capture the attending's plan along with their signature.

III. CORRECTIONS

When an error is made while documenting in the EHR, corrections must be made by the author of the original entry as follows:

1. The original entry must be visible.

2. Document the reason for the correction/error.

3. Use current date and time for the correction.

4. In situations where there is a hard copy printed from the EHR, the hard copy must also be corrected.

Reviewed and approved by:
Medical Executive Committee - 1/2023

Beverley A. Petrie

Beverley A. Petrie, M.D.
President, Professional Staff Association

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APPENDIX A:

	Time to initial completion in record	Document attending supervision	Forward for signature of	Time to sign by attending
Admission of 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 / UC 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