COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

POLICIES AND PROCEDURES

SUBJECT: MEDICAL RECORDS DOCUMENTATION

POLICY NO: 390.1

PURPOSE: To establish standards for proper medical records documentation, which is essential to (1) providing quality care, (2) providing information necessary for third-party billing and regulatory agencies, and (3) providing a legal record of the care rendered.

POLICY: All Department of Health Services (DHS) workforce members who are authorized to document in a patient's medical record shall comply with established standards.

DEFINITIONS:

Workforce or Workforce Members
Employees, volunteers, trainees and other persons whose conduct, in the performance of work for DHS, is under its direct control, whether or not they are paid by the County.

Medical Record
The compilation of all documentation concerning a person's healthcare in a given healthcare facility.

Provider
For purposes of this policy, a provider is a person who provides care (may be a physician, nurse, technician, allied health professional, etc.).

STANDARDS: Regulatory, accreditation and professional standards mandate the accurate and complete recording of pertinent facts, findings and observations about a patient's health history, including past and present illnesses, examinations, tests, treatments and outcomes. To that end, DHS has adopted the following documentation standards for its medical records:

I. GENERAL GUIDELINES

All documentation in medical records, including all dictated information, shall be timely, accurate and complete.

A. All documentation shall be legible and shall contain only authorized abbreviations and symbols.

B. Dates, times, signatures and titles are required at the time each entry is made. Additionally, late entries (notes that are recorded out of time sequence with existing notes) must be designated as a "late entry." Electronic signatures do not require a separate date and time if that information is automatically recorded by the system.

C. Signatures must be legible, or the name shall be printed below the signature.

D. Authorized users of signature stamps or computer keys shall sign a statement assuring that they alone will use the stamp or key.

E. Each page shall include identifying information including, at least, patient's full name, date of birth (if known), gender and medical record number.

F. Providers must review previous notes by other providers at the time of documenting a progress note to ensure continuity and consistency in the record.

G. Corrections to medical record entries shall be made so that the original entry remains readable (i.e., by drawing one line through the entry) and the correction dated, timed and initialed. Also, notes recorded to clarify previously written information must make reference to the prior note being clarified.

II. MEDICAL RECORD CONTENT

Clinicians providing patient care shall be responsible for preparing medical record documentation, which must include, but is not limited to:

A. The reason for the visit, admission and/or care.

B. Relevant history and physical examination findings.

C. Assessment, clinical impression and/or diagnosis, including the assessment of diagnostic test results.

D. Sufficient information/rationale to support the diagnosis/condition and to justify the medical necessity for admission, continued care, treatment and/or service.

E. Plan for care.

F. Evidence of patient informed consent, if required.

G. Description of therapeutic procedures performed.

H. The patient's progress, response to treatment (including any complications), changes in treatment, and revision of diagnosis, if any.

III. **DOCUMENTATION OF COMPLICATIONS AND/OR ADVERSE EVENTS**

A. Adverse events must be documented.

B. Documentation must note that the patient and/or family were informed of the complications/adverse event, when possible. If not informed, the reason must be noted.

C. Documentation following a complication/adverse event must include the plan for continuing care.

IV. DOCUMENTATION OF DISAGREEMENTS

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

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

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

V. ENFORCEMENT OF STANDARDS

A. Each workforce member with medical record documentation responsibilities must be trained on these standards. Managers of workforce members with medical record documentation responsibilities shall ensure that such training is documented.

B. Each manager of workforce members with medical records documentation responsibilities is responsible for implementation of these standards within his/her area of responsibility.

C. Compliance with these documentation standards must be included in the division's quality review and, if appropriate, in the individual performance evaluation.

D. If a review determines a need for further education or other remediation related to documentation, this education or remediation shall occur and be documented.

AUTHORITY: California Code of Regulations, Title 22, Sections 70749, 70751 and 75055

42 Code of Federal Regulations, Section 482.24

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CROSS
REFERENCES: DHS Policy 361, Confidentiality of Patient Medical Records and Information