County of Los Angeles **Department of Health Services**

VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
DEPARTMENT OF EMERGENCY MEDICINE
POLICY & PROCEDURE

NUMBER: 3239
VERSION: 1

SUBJECT/TITLE: **MEDICAL RECORD**

POLICY: DEM Patient's Medical Record

PURPOSE: To provide documentation of care rendered in the DEM.

DEPARTMENTS: **DEPARTMENT OF EMERGENCY MEDICINE (DEM)**

DEFINITIONS: To specify required documentation elements of a patients medical record.

PROCEDURE: A medical record is maintained on every patient seeking emergency care and is incorporated into the patient permanent medical record.

All prior, pertinent and ambulatory care patient medical record documentation, including previous visits to the Department of Emergency Medicine/Service are available when requested by the attending physician or other authorized individual.

The following information is entered in the patient medical record on each visit.

1. Patient identification (when not available, reason entered).
2. Time and means of arrival.
3. Pertinent history of illness or injury and physical findings, including patient vital signs.
4. Emergency care given to the patient prior to arrival.
5. Diagnostic and therapeutic orders.
6. Clinical observations including the results of treatment.
7. Reports of procedures, tests and results.
8. Diagnostic Impression

9. Conclusion at the termination of evaluation/treatment including final disposition, the patient's condition on discharge or transfer and any instructions given to the patient and/or family for follow-up care.

10. Patient leaving against medical advice.

11. The medical records is authenticated by the practitioner who is responsible for its clinical accuracy.

12. Ambulance record of the patient, if available, is attached to the Department of Emergency Medicine patient record.

13. A consultation form must be completed for all referrals to Specialty Clinics, a copy of the medical record will be made available, if desired.

14. An electronic log will continuously maintain and include at least the following information for every individual seeking care: identification (such as name, age, sex), date, time and means of arrival, nature of complaint, disposition and time of departure.

15. When authorized, a copy of the medical record of emergency service provided is available to the practitioner or medical organization responsible for follow-up care.

DEM CHART RESPONSIBILITY

Initial Contact Nurse documents via ATEMM (Advanced Triage Emergency Medicine Management - electronic medical record):

1. Name, Date of Birth, Age and Sex
2. Arrival time and means of arrival.
3. Chief Complaint
4. Priority level

Vital Sign and ECG Nurse documents via ATEMM:

1. Vital Signs
2. Attaches ECG to medical record on indicated patients.

Registration:

1. Records intake information on ATEMM and Affinity.
2. Assigns MRUN .
3. Signed consent form.
4. Prints out Patient name band and labels

Triage Nurse documents via ATEMM:

1. Confirmation of chief complaint

2. Pertinent assessment
3. All collected data i.e. weight, if indicated, allergies, immunizations, if indicated, blood sugar, pain and pain assessment worksheet, suicide risk, fall risk.
4. ESI level

Nursing Clerk:

1. Compiles and completes the medical record for utilization by physicians and nursing. Labeling each form and copy.
2. Enters all physician orders into HIS and documents order numbers. Obtains barcode labels.
3. Adds to individual medical records, as indicated, lab results, completed history and physical, patient progress notes, nursing data documentation., consultations, consents, physician orders, documentation from outside agencies and discharge forms including patient education/instructions, medication list, recommended follow-up/consultations, provider and nurse identification, and any other form specific to the patient and required to be included in the medical record.

General Considerations:

1. Consents and patient instructions are in English and Spanish. Interpreters or Interpreter system is utilized and documented.
2. All entries are dated, timed and authenticated. Signatures should be legible.
3. Since ATEMM is not a complete EMR copies of the patient's charts are kept in a departmental "pink" file.

References:	
Approved by: David Talan (Chief Physician), Jeanne Egusa (Nurse Manager), Vena Ricketts (DEM PI/QI Coordinator)	Date: 06/30/2011
Review Date: 12/92, 12/95, 2/96, 12/98, 12/00, 2/01, 11/01, 3/02, 3/04, 3/05, 12/07, 2/11, **06/30/2014**	Revision Date: 12/20/07, 2/22/2011
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