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

OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 1370
VERSION: 3

SUBJECT/TITLE: **PHYSICIAN COMPLETION OF ELECTRONIC HEALTH RECORDS**

POLICY: To assure that medical staff completes medical records in a manner that meets the requirement of licensing agencies, the standards of the Joint Commission and the policies of the Department of Health Services.

PURPOSE: Title 22 requires the medical records of all discharged patients must be completed within 14 calendar days after discharge. This policy shall foster and engender the successful completion of accurate medical records. Olive View-UCLA Medical Center's medical records shall reflect the level of care received as these records are a source of training, research and communication between health professionals and serve as documented proof of service rendered for fiscal and medical/legal purposes.

DEPARTMENTS: **ALL**

PROCEDURE:

1. A complete **Admission History** **and** **Physical Examination** shall be recorded in the patient's chart and signed by both the resident and attending physicians within 24 hours of admission.
2. To avoid misinterpretation, **Symbols and Abbreviations** may be used in the medical record only when they have been approved by the medical staff.
3. **Timely Progress Notes** shall be **legibly written** by medical staff to give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition and the results of treatment. Progress Notes shall include a date, time, and legible signature and title.
4. **Operative Reports** must be written or **dictated immediately** after the surgical procedure (same day of surgery) and electronically signed within 48 hours from the date of dictation.
5. To the extent possible, order for treatment shall be in writing. **Verbal Orders** of authorized individuals must be accepted and transcribed by qualified personnel, who are identified by title and category in the Medical Staff Rules and Regulations. Such orders must be authenticated by the practitioner responsible for the patient who gave the verbal order signs, dates and times the order within 48 hours.
6. **Attending Notes** are required on all inpatients within 24 hours of inpatient admission.
7. **Admitting Orders** must be written for each patient who is admitted to the ward. Admitting orders must consist of admitting diagnosis, name of the admitting physician, activity, diet and frequency of vital signs. Admitting orders must be countersigned by the admitting physician.

8. **Discharge/Transfer/Death Summaries** must be dictated/documented on each inpatient discharged from the facility. The discharge summary must consist of the following: reason for hospitalization, discharge diagnosis, significant findings, and procedures performed, and treatment rendered, the patient's condition at discharge, recommendations and arrangements for future care, instructions to the patient and family about activity limitations, wound care and diet if applicable and disposition.
9. Psychiatric discharges require a signed and dated **Case Management/ Discharge Plan** by the resident and co-signed by the attending physician.
10. **Medical Records** of discharged patients shall be completed within 14 calendar after discharge.
11. All Medical Records of discharged patients shall be released to the Discharge Clearance Unit (DCU) within 24 hours of discharge.
12. All Medical Records of outpatients shall be released to Scanning Unit immediately after the patient is discharged from clinic.

The following actions will be taken by Olive View-UCLA Medical Center's Health Information Management (HIM) Administration to ensure compliance with this policy:

I. **Notification of Incomplete Medical Records**
HIM will provide the Service Chief with a list of physicians with delinquent medical records. A copy will be sent to each of the affected physicians, Hospital Administration and Medical Administration.

II. **Responsibility of Service Chiefs**
   A. Service Chiefs will be accountable for monitoring the list of physicians with delinquent medical records and ensuring that physicians complete the charts for which they are responsible.
   B. Service Chiefs will take appropriate corrective action in case where delinquent medical records have not been completed within three (3) working days following notice to the physicians. Such corrective may include the following:
      1. Withdrawal of all or part of the following:
         a. Ward activities
         b. Participation in operating room or surgical procedures
         c. Clinic assignments
         d. Section 170 items
         e. Overtime assignments
         f. Stand-by assignments
         g. Use of the medical library
         h. Attendance at hospital conferences
      2. A non-completion rating to the physicians for the rotation on which delinquent medical records are incurred.

3. Any department, which exceeds the Joint Commission standards on a departmental basis in any month, will have a one-month suspension of County-approved travel time privileges.

References: Title 22, Code of Regulations 70749, 70751, 70551, CMS Regulations Joint Commission	
Approved by: Bonnie Bilitch (Chief Nursing Officer), Judith Maass (Chief Executive Officer), Rima Matevosian (Chief Medical Officer)	Date: 02/03/2020
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