OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 181
VERSION: 4

SUBJECT/TITLE: **MEDICAL RECORD DOCUMENTATION**

POLICY: All Olive View-UCLA Medical Center workforce members who are authorized to document in a patient's electronic medical record shall comply with established standards.

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

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, outcomes.

DEPARTMENTS: All

DEFINITIONS: **Workforce or Workforce Members** are employees, volunteers, trainees, and other persons whose conduct, in the performance of work for Olive View-UCLA Medical Center, is under its direct control, whether or not they are paid by the County.

Electronic Medical Record is the compilation of all documentation concerning a person's health care in a county facility.

Provider, for the purposes of this policy, is a person who provides care (e.g., a physician, nurse, technician, allied health professional, etc.)

Time of Admission is the time at which the admitting order has been written.

Consultation is advice given by a consulting physician, on specific request of another physician or other privileged provider, regarding the evaluation or management of a specific patient.

PROCEDURE:

I. General Guidelines

A. All documentation in the electronic medical records, including all dictated information, shall be timely, accurate, and complete. Timely generally indicates entry on the day the event occurred, but other

policies or rules may apply to other notes (e.g., nursing notes, operative notes, or admission notes).

B. All documentation shall be legible.

C. Dates, times, signatures, and titles are required at the time each entry is made.

D. Electronic signatures do not require a separate date and time if that information is automatically recorded by the system.

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

F. Each page shall include identifying information including, at least, the patient's full name, and one of the following: MRN or date of birth.

G. Corrections to medical record entries shall be made so the original entry remains readable (e.g., 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

A. History and Physical examination

1. History and physical examinations must contain the following:
   a. Chief complaint/reason for the visit, admission, and/or care
   b. History of present illness
   c. Immunization status for patients under 16 years of age
   d. Family history and social history
   e. Review of systems
   f. Physical examination
   g. Laboratory data, if available
   h. Assessment(s) and diagnosis(es) or diagnostic impression(s)
   i. Assessment must include sufficient information/rationale to support the diagnosis/condition, and to justify the medical necessity for admission, continued care, treatment, and/or service.
   j. Plan(s)
2. The admission history and physical examinations must be recorded in the patient's medical record within twenty-four hours of admission, or a note placed in the chart which updates a history and physical examination done within 30 days of admission

B. Admitting Orders

1. ORCHID Computerized Physician Order Entry solution is the vehicle used by medical providers to establish admitting orders for each patient who is admitted to the inpatient service.

Admitting orders must consist, at a minimum, admitting diagnosis, name of admitting physician, activity, diet and frequency of vital signs.

C. Attending Notes
1. Evidence of attending supervision is required as described in the DHS Supervision of Residents Guidelines.
2. Attending notes are required when documenting discussions and decisions leading to 'do not resuscitate' (DNR) orders.

D. Progress Notes
1. Progress notes contain the patient's progress, response to treatment (including any complications), changes in treatment, and revision of diagnosis, if any.
2. **Providers must review previous notes by other providers** at the time of documenting a progress note to ensure continuity and consistency in the record.

E. Consultation Notes
1. All requests for consultation shall be documented in the Electronic Medical Record (EMR).
2. Consultants shall document their assessment and recommendation in the medical record, noting the name of the consult service in the title of the note.

F. Telephone/Verbal Orders (Refer to Olive View-UCLA Medical Center Verbal/Telephone Order P&P #1037 for additional information)
1. The entire Telephone/Verbal orders must be read back to the prescriber after it is documented in the electronic medical record. Read back includes:
   a. Two patient identifiers
   b. Repeat the name of the drug
   c. Repeat the dosage order
   d. Request or provide correct spelling.
2. A provider, who is a member of the patient care team, will sign orders in the electronic medical record as soon as possible and no later than 48 hours after the order is written.

G. Discharge Summaries
Discharge summaries must be dictated on each patient discharged from the facility. Discharge summary must include, at a minimum, the following:
1. Discharge diagnosis(es)
2. The reason for hospitalization

3. Significant findings
4. Procedures performed
5. Treatment rendered
6. Patient's condition at discharge
7. Recommendations and arrangements for future care
8. Instructions about activity limitations and diet, and
9. The complete list of medications, if any.

H. Procedure Note

1. A procedure note must be completed for all non-OR procedures that require an informed consent.
2. The procedure note must include the following:
   a. Name of licensed independent practitioner and assistants
   b. Procedure(s) performed including description, date and time
   c. Clinical indication for procedure(s)
   d. Presence of informed consent (when indicated)
   e. Verification of correct patient, procedure, site, equipment and "time out"
   f. Medication(s) administered
   g. Findings, specimen(s) removed and/or estimated blood loss if any
   h. Complication(s) and/or indication for post-procedural review if any
   i. Patient status post-procedure
   j. Physician signature

III. Abbreviations

A. Any abbreviations in the medical record that are not clear to the reader shall be clarified by the writer.

B. Banned abbreviations

1. The following abbreviations are banned:

U	write out 'units'
IU	write out 'international units'
QD, qd	write out 'daily'
QOD	write out 'every other day'
MS	write out 'morphine sulfate'
MSO4	write out 'morphine sulfate'
MgSO4	write out ' magnesium sulfate'
Trailing zeros are	write '20', not '20.0'

not allowed	
Leading zeros are required	write '0.75', not '.75'

2. Banned abbreviations are prohibited in all orders and all medication-related documentation in the medical record when handwritten or entered as free text into a computer.

3. If banned abbreviations are observed within a medication order, Nursing and/or Pharmacy will obtain clarification prior to medication being dispensed and administered.

4. Preprinted forms will not include any banned abbreviations.

IV. Documentation of Non-Face-to-Face Conversations with Patients

A. Providers will document under an appropriate section of the EMR all clinically relevant non-face-to-face encounters with patients. Non-face-to-face encounters refer to telephone conversations, emails, text messages, or other non-verbal methods of communication.

B. Documentation will include the following information and will be placed in the medical record:
   1. The date and time of the encounter
   2. The name of the person who initiated the encounter (e.g., the patient, provider, patient's relative)
   3. The nature of or the reason for the encounter
   4. Clear and concise documentation of advice or counsel given, if any
   5. Clear and concise documentation of follow-up instructions given, if any
   6. The signature of the person documenting the encounter (and giving the advice/instructions, if applicable)

C. All relevant policies on patient privacy and compliance with HIPAA shall be followed in all forms of communication with patients at all times.

V. 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.

VI. 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.

VII. 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/unit's **quality review** and, if appropriate, in the **performance evaluation** of individual workforce members.

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.

References: California Code of Regulations, Title 22, §§70749, 70751, and 75055 42 CFR §482.24 CMS Conditions of Participation: Medical Staff History and Physical Examination, Nursing Services - Authentication of Verbal Orders DHS Policy 390.1, "Medical Records Documentation"	
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