LAC+USC MEDICAL CENTER POLICY

Subject:	Original Issue Date:	Policy #
HEALTH/MEDICAL RECORD: DOCUMENTATION	6/30/75	**403**
	Supersedes: 11/18/08	Effective Date: 10/10/17

Departments Consulted:	Reviewed & Approved by:	Approved by:
Health Information Management Information Management Nursing Services and Education Medical Administration Health Information Committee	Attending Staff Association Executive Committee Senior Executive Council	Chief Medical Officer Chief Executive Officer

PURPOSE

To establish LAC+USC Medical Center standards for health/medical record documentation in accordance with regulatory, accreditation, and Department of Health Services standards.

To assure that all pertinent information gathered and care delivered are documented in the patient's health/medical record.

POLICY

The health/medical record maintained in LAC+USC Medical Center component facilities shall contain sufficient information to identify the patient, assess the initial complaint, design the plan of care as supported by the diagnosis, document the course and results accurately and legibly, and facilitate the continuity of care by the multidisciplinary team.

PROCEDURE

- Health/Medical Record Documentation Criteria shall include: the date, time, electronic signature statement, provider name and credential on each entry.
- Documentation on paper shall be recorded in black ink and shall include the signature and unique hospital identification of the licensed attending physician of record and/or all other levels of physicians, fellows, and/or post-graduate trainees.
- In accordance with statutory requirements for credentialed professionals, all entries documenting the patient care shall be signed by the individual with the category designation rendering care.
- To facilitate consistency and continuity in patient care, patient-specific information is provided to support timely, accurate, secure, and confidential recording as outlined in the Attending Staff Manual and regulatory standards.
- Verbal orders, including telephone orders, shall be given only to a registered nurse or physician's assistant with time order was given, and only in an emergency. The order shall be documented in the health/medical record immediately by the professional receiving the order and must be signed, dated and timed.

- The issuing practitioner shall authenticate each verbal order in the health/medical record with date, time, signature, within 24 hours.

- Reports pertaining to clinical/diagnostic assessment, evaluation, and/or treatment shall reflect the technical procedure used, specimen obtained, findings, and diagnosis.

- Operative or other invasive procedures notes, and/or anesthesia shall be documented on the health/medical record immediately after surgery and a full report, consisting of a complete summary of the operation or procedure, shall be placed into the electronic health record system within 24 hours of the procedure or operation. Report may be dictated or handwritten into the electronic health record.

- Drug/food interaction education shall be explained to the patient and shall be documented in the health/medical record by the professional providing the patient education.

- Discharge planning shall be completed for each patient prior to discharge. The plan shall be documented in the health/medical record by all the appropriate professional services involved in the patient's care.

- Documentation may be recorded electronically using the approved electronic medical health record system; the standards required for handwritten notes and assessments shall apply to electronic notes entered into patient charting (e.g., notes shall include date, provider's electronic signature and time and date stamped by the system, etc.)

RESPONSIBILITY

Administration
Attending Staff
Housestaff
Mid-Level Providers
Allied Health Professionals
Nursing Staff
Health Information Management

PROCEDURE DOCUMENTATION

Attending Staff Manual
Health Information Management Policy and Procedure Manual

REFERENCES

California Code of Regulations, Title 22, Sections 70749, 70223(f-h)
Joint Commission Standards (Management of Information)

REVISION DATES

August 1, 1995; October 20, 1998; April 9, 2002; March 23, 2004; November 18, 2008; November 12, 2013; October 10, 2017