Name of Policy:	**Documentation in the Medical Record**	THE UNIVERSITY OF TOLEDO MEDICAL CENTER
Policy Number:	3364-110-07-02	
Department:	Nursing Service	
Approving Officer:	Chief Nursing Officer	
Responsible Agent:	Chief Nursing Officer	**Effective Date:** 6.1.2023
Scope:	The University of Toledo Medical Center (UTMC)	Initial Effective Date: June, 1978

_____ New policy proposal	__X__ Minor/technical revision of existing policy
_____ Major revision of existing policy	_____ Reaffirmation of existing policy

(A) Policy Statement

Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Nursing Assistants (NAs), Patient Care Technicians (PCTs), Medical Assistants (MAs), Rehabilitation Technicians, Mental Health Aides (MHAs) and Mental Health Technicians (MHTs), who have been trained in documentation procedures, are to document all patient care in the Electronic Medical Record (EMR). Paper entries need to be legible, signed, dated, and timed.

(B) Purpose of Policy

To establish a uniform procedure for accurate and timely documentation.

(C) Procedure

1. Hospital Policy #3364-100-53-26, "Electronic Health Record-Use of Templates and Copying Functionality" must be followed.

2. Documentation should relate accurate, descriptive, and factual information and should be comprehensive while showing evidence of the nursing process. Entries should be done in a timely manner and should reflect the following:
   a. Patient care provided
   b. The nursing process
   c. Observations of physical and functional characteristics
   d. Patient progress
   e. Treatments, medications, and interventions and the patient's response
   f. Significant changes in patient condition
   g. Psychosocial aspects
   h. Adverse or abnormal occurrences and actions taken in response
   i. Patient and/or family education
   j. Discharge planning
   k. Significant medical history
   l. Environmental and/or equipment needs

3. Verbal orders accepted by RNs or clinic MAs (only in assigned clinics and only with signed written agreement from each clinic physician) must be written according to approved guidelines for orders.

4. When documentation is done by someone other than the actual care provider, the provider's name should appear in the entry. Student documentation must be confirmed by the RN responsible for that patient's care or the Clinical Instructor.

5. Only hospital approved abbreviations and forms are to be used for documentation in EMR.

6. Documentation of the nursing process on the medical record will follow Charting Guidelines.

7. All entries should be made in an organized manner and will be recognized as confidential information.

Approved by:	**Review/Revision Date:**
/s/ Kurt Kless, MSN, MBA, RN, NE-BC Chief Nursing Officer Date *Review: Policy & Standard Committee, 4/12, 5/15, 4/2020, 6/1/2023* *Revision Completed By: Nancy Gauger, MSN, RN;*	1979 1987 5/2001 1980 1988 11/2004 1981 1989 11/2007 1982 1990 8/27/2008 1983 3/1993 6/16/2010 1984 1998 4/27/12 1986 4/2000 5.22.15 4.1.2020 6.1.2023 **Next Review Date:** 6/2026
Policies Superseded by This Policy:	