(A) Policy Statement

Entries in the patient's medical record must be legible. Authorship in the patient's medical record must be clearly and easily identified.

(B) Purpose of Policy

Entries in the patient's medical record must be legible. Authorship in the patient's medical record must be clearly and easily identified.

(C) Procedure

1. The following personnel are permitted to make entries into the medical record:
   - Physicians
   - Nurses
   - Physical/Occupational/Speech Therapists
   - Pharmacists
   - Members of the Rehabilitation Team
   - Social Workers
   - Respiratory Therapists
   - Child Life Instructors
   - Registered Dieticians
   - Care Coordinators
   - Organ Procurement Coordinators
   - Students
   - Pastoral Care
   - Ethicists
   - Medical Assistants
   - Physician Assistants
   - Mental Health Technicians
   - Nursing Assistants
   - Patient Care Aides
   - Exercise Physiologists
   - Professional Counselors
   - Psychology Assistants
   - Certified Chemical Dependency Counselors
   - Psychologists
   - Psychology Interns, Externs, Fellows
   - Therapeutic Recreational Specialists
   - Special Education teachers
   - Dentists
2. Entries must be legible, signed and dated. **Timing of entries is required.**

3. Each clinician documenting in the medical record must print his or her name legibly with the recorder’s first initial, last name and title underneath his or her signature or stamp and document the service with a header (Ex.: Internal Medicine Note), the first time a health care provider signs the chart.

4. Entries of nursing and other allied health professionals should be appropriately initialed or signed. If initialed, the initials must be identified on each sheet with the signature including first initial and full last name.

5. When an error occurs in the entry of information in a medical record, a line should be drawn through and the word “error” written on the line. This is followed by the recorder’s name, title, date and time. The proper information is then documented. Late entries should be prefaced by the word “late entry” with the date and time.

6. **Required Co-Signatures**

<table>
<thead>
<tr>
<th>Practitioner/Service</th>
<th>Co Signed by</th>
<th>Type of Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Nurse Practitioner</td>
<td>Attending Physician</td>
<td>• Informed Consent prior to surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inpatient H &amp; P (if surgery patient, prior to surgery)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Orders if CNP does not have prescribing authority</td>
</tr>
<tr>
<td>Anesthesia Assistant</td>
<td>Anesthesiologist</td>
<td>Anesthesia Evaluation</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist (CRNA)</td>
<td>Anesthesiologist</td>
<td>Anesthesia Evaluation/Record</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Attending Physician</td>
<td>• H &amp; P (if surgery patient, prior to surgery)</td>
</tr>
<tr>
<td>Exercise Physiologist</td>
<td>Attending Physician</td>
<td>• All Entries</td>
</tr>
<tr>
<td>Physician Assistant (PA)</td>
<td>Attending Physician</td>
<td>• Informed consent prior to Surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• H &amp; P (if surgery patient, prior to surgery)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Orders within 24 hours and prior to actions taken on order</td>
</tr>
<tr>
<td>Psychology Assistant (PA)</td>
<td>Psychologist</td>
<td>• All entries</td>
</tr>
<tr>
<td>Registered Nurse First Assistant (RNFA)</td>
<td>Surgeon</td>
<td>• H &amp; P (if surgery patient, prior to surgery)</td>
</tr>
<tr>
<td>Residents</td>
<td>Attending Physician</td>
<td>• Operative Progress Note</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Ordering Physician</td>
<td>• Dosing orders and monitoring</td>
</tr>
</tbody>
</table>

Use of Signature Stamps

1. Physicians using rubber stamp signatures must sign the Confidentiality Statement whereby stating that he/she will be the only one using the stamp.
2. The signed Confidentiality Statement is kept on file in the Medical Staff Office.
3. The use of the signature stamp is for identification purposes only. Physicians are to sign above the signature stamp for proper authentication of a medical record entry.

Physician Electronic Signature on Transcribed Reports

1. Physicians are required to sign transcribed reports with a digital signature.
2. Each user is trained on the appropriate use of the digital signature system for Radiology reports and for general medical record reports i.e., history and physicals, consultations, operative reports and discharges.
3. A signed Confidentiality Statement verifies that the user’s computer password and file access codes are not shared.
4. Violation will result in appropriate corrective disciplinary action.
5. The computer sign-on and the default password are distributed at the training session for the signing of general medical record reports. The system prompts the physician to change the default password at the time the physician first logs onto the electronic system. In Radiology, the password is established at the time of training.
6. Within the electronic signature systems, there is a two level access control mechanism; a unique login ID and password known only to the user. The password cannot be viewed on the screen.
7. Both electronic signature systems require that documents must be electronically retrieved/reviewed individually before a signature can be affixed to each document.
8. For security purposes, PCs that are left inactive for a number of minutes are automatically logged off.
9. At the end of the electronic system session for signing history and physicals, operative reports, etc., the physician password is again entered before the digital signature is applied and finalized. In the Radiology system, there is a verification process before a digital signature is affixed.
10. Along with the signature, both systems automatically place a date/time stamp adjacent to the digital signature.
11. Once the report is signed, it cannot be edited or changed.

The above policies and procedures for physician electronic signature of transcribed reports are required under the Ohio Revised Code (ORC) 3701.75.

Approved by:

[Signature]
Carl Sirio, MD
Chief Operating and Clinical Officer

Date: 9/1/17

[Signature]
Thomas Schwann, MD
Chief of Staff

Review/Revision Date:
6/9/99
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8/9/06
5/28/2008
4/1/2011
9/1/2014

Next Review Date: 9/1/2017

Policies Superseded by This Policy: 7-53-18 – Handwritten Entries in the Medical Record, Signature Stamps, And Electronic Signatures on Transcribed Reports

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.