(A) Policy Statement

Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Nursing Assistants (NAs), Medical Assistants (MAs), Rehabilitation Technicians, 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 #3364-100-53-18, "Handwritten Entries in the Medical Record" 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. (Refer to Hospital Policy “Verbal Orders” #3364-100-53-16).

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.
Policy 3364-110-07-02
Documentation on the Medical Record
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Approved by:

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Director of Nursing/CNO

Review/Revision Date:

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Next Review Date: 5/2018

Policies Superseded by This Policy: