A) Policy Statement

Documentation will occur on all patients who are screened, assessed and followed by the Outcome Management staff.

B) Purpose of Policy

To establish a standard for medical record documentation, in the Care Organizer system and the Outcome Management Referrals Section of the Discharge Instructions in Care Organizer, of staff’s interventions, services and care. This documentation is to be professional, accurate, legible and timely. Documentation will ensure continuity of patient care and communication with the health care team.

C) Procedure

1. Medical record documentation includes completion of the Discharge Planning Assessment form, progress note documentation, case management, team meetings and multidisciplinary reports.

2. All notes will be headed with the current date and time, under the tab in the Discharge Planning Tab in the Care Organizer system.

3. All notes will be signed with the staff member’s full name, credentials and position.

4. Staff will document in the Discharge Planning Tab in Care Organizer for documentation of patient needs and or plans.

7. Documentation should be concise and identify pertinent facts. The purpose of the electronic note should be clear (i.e. provide information, record activity or request action).

8. Discharge disposition should be identified in the Outcome Management Referrals Section of the Discharge Instructions (i.e. active, inactive, pending, monitored, will follow, etc).

9. All active case documentation should occur with change in patient need, change in level of care, or more often as needed.

10. All active cases will have updated notes every Friday for weekend coverage needs.

11. Documentation should be logical and read smoothly to identify the intervention, care and or discharge plan progression.

5. Documentation errors should be addressed per Care Organizer’s mechanism to do so.
6. Staff will document a final entry in the patient’s medical record progress note, via the Discharge Planning tab in Care Organizer, summarizing all pertinent information and plans. Referral information will be documented in the Outcome Management Referrals Section of the Discharge Instructions form located in Care Organizer.

7. Personal beliefs, values, judgment statements and staff personal opinions should not be documented in the chart.

Approved by:

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Review/Revision Completed By:
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Policies Superseded by This Policy: 17-04 Outcome Management Documentation

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