Pennsylvania Hospital & Surgery Center

ADMINISTRATIVE POLICY MANUAL

SUBJECT: MEDICAL RECORD DOCUMENTATION PRACTICES

POLICY NUMBER: IM10

Effective: 0408

POLICY

For purposes of this policy, Pennsylvania Hospital includes all off campus licensed facilities, including but not limited to the Surgery Center of Pennsylvania Hospital.

Medical record entries shall be documented in a manner that meets the requirements of the legal and regulatory agencies with jurisdiction over the Hospital and the Joint Commission accrediting standards. The medical record, whether paper or electronic, shall be free from inadvertent or intentional alterations. There shall be no change or deletion whatsoever of recorded data in the medical record. Entries shall be made only by users who are authorized to document within the medical record. Authorized users shall provide clear and legible documentation of the patient’s condition according to all guidelines.

PURPOSE

The purpose of this policy is to identify the personnel who are authorized to document in the medical record and to outline guidelines for medical record entries including corrections, alterations, legibility, late entries and addenda.

PROCEDURE

AUTHORIZED USERS:

Persons who may document in the medical record include the following:

a) Attending physicians, house staff, Certified Nurse Midwives and other individuals who have been granted clinical privileges;

b) Nursing health care providers including registered nurses, LPNs and others responsible to the nurse manager or physicians;

c) Professionals responding to a request for consultation when the professional has clinical privileges or is an employee (or house staff member) or a member of a Medical Staff Committee (e.g., Ethics Committee);

d) Other health care professionals involved in patient care, including but limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, case managers, and chaplains;

e) Volunteers, such as volunteer chaplains, functioning within their approved roles

f) Students in an approved professional education program who are involved in patient care as part of their education process may document in a medical record if that documentation is reviewed and countersigned by the student’s supervisor who must also be an authorized user;

g) Authorized non-clinical and administrative staff may document in the medical record as appropriate.
GENERAL ENTRIES

- Entries in the medical record shall be continuous with no blank pages, lines or spaces. A line shall be drawn to the end of the page when an entry does not fill the page.
- Entries shall be made in permanent black ink (preferred) or blue ink. Using other colors is discouraged. Pencil may not be used.
- All entries must be in chronological order. All entries shall be dated, timed and signed at the time the entry is written. Signatures shall include credentials. Each electronic entry shall be individually authenticated by use of user identification and password.
- Symbols and abbreviations may be used only if approved by the Medical Records Committee. Abbreviations on the “Dangerous Abbreviations” List are not to be used.
- The attending Professional Staff appointee for each patient shall be responsible for the preparations and completion of the medical record. However, he/she can countersign history and physical examinations written by a member of the House Staff. He/she does not have to countersign progress notes, treatment orders or other entries written by House Staff in accordance with the Professional Staff Rules and Regulations.
- The patient’s name must appear on every page or document that contains patient information.
- All entries must be legible.

CORRECTIONS AND ALTERATIONS

- Corrections shall be done in a manner that does not obliterate the original entry. Use of white-out is not permitted. No erasure or eradication is permitted. If an error has been made, a single line shall be drawn through the error, labeled as an error, the correction made, dated and initialed.
- Pages of medical records shall not be removed, torn out or cut. Any actions which may be construed as tampering with the record must be avoided.
- Patient requests to amend records shall be handled in accordance with the Hospital’s “Patient’s Right to Request Amendment of their Protected Health Information (HIP3)” policy.

/s/Kathleen Kinslow 05/05/08
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Executive Director

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