SECTION - MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 590
(Replaces A.D. No. 590 dated 1/11/07)

Effective Date: May 10, 2007

SUBJECT: DOCUMENTATION STANDARDS

I. PURPOSE

To provide and maintain the Medical (Clinical) Record for the benefit of the Individual, the clinician, and the facility, while safeguarding the record and its contents from loss, damage, tampering and unauthorized use. To maintain documentation within the Medical Record in a clear and concise manner that meets all regulatory standards.

II. AUTHORITY

California Code of Regulations (CCR) Title 22, Sections 71547(c) and 71551(g).

III. POLICY

It is the policy of Coalinga State Hospital (CSH) to maintain medical records in accordance with all applicable regulations, to provide permanent, legal documentation to substantiate the treatment rendered to the Individual.

IV. METHOD

A. The Medical Record is a confidential document. Anyone, other than the treatment team, who is allowed to access the record must sign the Record Review Log located at the front of the chart.

B. The Medical Record must be written in a timely manner and contain sufficient information to identify the Individual, support the diagnosis, justify the treatment, and accurately document outcomes of treatment.

C. All entries must be legible.

D. Discharge records must have documentation from Medical, Psychiatry. Social Services and Nursing prior to discharge.

E. Health Information Management Department (HIMD) will complete assembly, coding, billing and entry into ADT system within the following timeframes.

1. Discharges from Acute level of care have 14 days to be completed.

2. Discharges from Intermediate Level of Care have 30 days to be completed.

3. HIMD completion includes:

   a. All loose filing inter-filed into chart.

   b. All dictation transcribed and signed.

   c. All corrections made.

   d. The chart coded and entered into the ADT System.

4. While all identified corrections need to be addressed, for the purpose of reporting delinquent charts, only those missing documentation or authentication by Physician, Psychologist, Podiatrist or Dentist will be reported as delinquent.

F. White out, correction fluid or correction tape (any devise that changes or alters an original entry) shall not be used in the Medical Record.

G. Each entry shall be dated, timed and signed by the person making the entry.

1. Dates are in standard format to include the month, day and year. Example: 05-19-07

2. Time refers to the time the note is actually being written. Time is written using a 24-hour clock, so 2:15 p.m. is written as 1415.

3. Signatures consist of first initial, last name, and title.

H. Use of signature stamps

1. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative office to the effect that he/she is the only person who:

   a. Has possession of the stamp or key.

   b. Will use the stamp or key.

I. Patient Identification is required on every page with patient documentation. Two sided pages require patient identification on both sides.

1. Identification consists of:

   a. Individual's full name (Doe, George)

   b. Hospital ID number (CO-000321-8)

   c. Date of birth (03-09-1948)

2. Use of the addressograph stamp will provide all required information, and is the preferred method.

3. The person writing the first documentation on a given page is responsible for stamping or including the name, number and birth date on the document.

4. Hand written information is acceptable but must contain the full name, hospital ID number, and date of birth.

J. Continuation of notes:

1. Notes that start on one page and continue onto the other side or to the next page must be identified.

2. At the end of the first section of the note write "Continued".

3. Where the second part of the note starts should start out with "Continued from other side" or "Continued from previous page".

4. You need only sign at the bottom of the completed note.

K. All chart entries shall be made in ink:

1. Black or dark blue ink only.

2. Red ink is used only for allergies, to D/C medications, and noting orders.

3. No felt or gel pens or pens that can smear when touched or water comes into contact with the entry.

L. Corrections of errors:

1. Draw a single line through the error. Never obliterate.

2. Sign with initial of first name and complete last name.

3. Enter the correct information.

4. Date & sign the entry.

	6-12-05	0930	John is standing at the window to nursing station, pounding on glass with ~~right~~ hand. ----------J. Anyone Left Error 6-12-05 J. Anyone
			Above is sample of correction

M. Correction of errors containing more then a few words:

1. Draw a single line through the error. Never obliterate.

2. Label as "error".

3. Place an "*" next to the error.

4. In the far left column place an "*" and "see late entry dated (give date)".

5. In the next available space enter the corrected information. At the beginning of the note label it "Late entry for (enter date original note was written)".

N. Late entries:

1. Enter an "*" in the far left hand column of the page where the original note should have been written.

2. Next to the "*" a notation of where to find the late entry "See late entry dated ____ at ____".

3. At the next available space enter today's date and time with a second "*" in the far left column. Begin your note with "Late entry for (enter date the note should have been written)".

*	6-13-05	1215	Refused lunch meal, says he is "not hungry". J. Anyone, PT *See late entry today at 1430
	6-13-05	1400	Resting comfortably on top of bed. M. Mays, PT
*	6-13-05	1430	Late entry for 6-13-05 at 1215 Complaining of headache, requested to go to dorm, refused PRN medication for headache. J. Anyone, PT
			Above is sample of late entry, same method is used for correction of more then a single word.

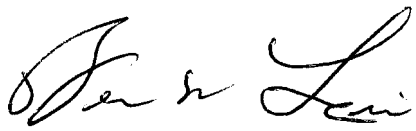
O. Identification of initials: Any time that initials are used on a document, such as a medication administration record, you must identify the initials with your full name and title.

P. Use of other Individual's name: You are not to identify another Individual by name. The Individual should be identified by their CSH number only.

Q. Extraneous remarks:

1. Documentation should relate to the Individual, their care, progress, treatment, activities and outcomes.

2. This is not the place to air personal issues, or identify departmental issues. Nor is it the appropriate place to document your personal feelings regarding other staff, working conditions, or areas of discontent.



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Executive Director (Acting)