TOPIC: MEDICAL RECORDS, MAINTENANCE OF

PURPOSE: To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.

To provide a chronological summary of the patient's medical evaluation, treatment and change in condition.

To document communication between the responsible practitioner and any other health professional contributing to the patient's care.

LEVEL OF RESPONSIBILITY:

Providers
Students
Residents
Nurses
Medical Assistants
Clerical Staff

POLICY:

It is the policy of PCC Community Wellness Center to maintain medical records that are accurate and timely; that are readily accessible, and that permit prompt retrieval of information. The record shall contain information to identify the patient, to support the diagnosis, to justify the treatment, and to accurately record the patient's clinical course.

PROCEDURES:

Medical Record Standards

1. Content of the Medical Records
    a) All medical records shall contain at least the following information:
        - Patient identification/demographic data
        - History and Physical examination completed by the third visit or a year after the first visit, whichever comes first
        - Problem and medication lists completed by the third visit or a year after the first visit, whichever comes first
        - Evidence of appropriately informed consent for treatment and procedures
        - Reports of procedures and tests
        - Clinical progress notes

Medical Record Entries

a) Entries in medical records shall be made only by individuals given the right as specified in PCC Community Wellness Center policies.
b) Entries shall be made at the time of the patient's visit.
c) Only approved clinic abbreviations will be used in chart notations.
d) All orders must be signed by a provider. Verbal and telephone orders must be signed within 24 hours.
e) Specific instructions for nursing personnel:
    - Pertinent observations, patient's statements about condition, changes in the patient's condition must be documented in EHR on proper encounter form
    - Document patient related calls using a PHONE NOTE and route to provider and indicate the reason for the call
    - All professional teaching must be documented on the progress notes and must include what was taught. If handouts generated through EHR, user should check box to record in chart.

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Revised: 5/02, 9/02, 8/05, 6/11, 5/12