Good Samaritan Health & Wellness Center
Policies and Procedures

Subject: CHARTING	Policy #: 5.18
Prepared by:	Revision #:
Approved by: Board of Directors	Effective Date: 7/24/2015

1.18 Charting

OBJECTIVE:

1. To document the health care services given to patients;
2. To establish permanent and continuous records of healthcare observations, interventions, and outcomes.
3. To serve as a communication channel for the health care professionals in the clinical management of the patient.
4. To furnish documentary evidence of illness and treatment.
5. To protect the legal interests of the patient, health care facility and the provider.

PROCESS/PROCEDURE:
The medical staff must document the care provided to a patient at each visit and in telephone correspondence. Documentation is to be completed on the date of occurrence.

1. Clinical staff must document all patient health care in ECW on the date the service was rendered.

2. Such documentation includes, but is not limited to the following:

    A. Completion of the health history on the first visit with ongoing updates as warranted. The information is to be obtained and entered by the nursing staff and reviewed by the provider.

    B. Completion and ongoing updates of the problem list with all chronic and recurrent acute health problems. The information is to be obtained and entered by the nursing staff and reviewed by the provider.

    C. Completion and ongoing updates of the medication list of all medications the patient is known to be taking including vitamins, herbal, and over the counter medications. The information is to be obtained and entered by the nursing staff and reviewed by the provider.

D. Completion of the comprehensive care notes including:
    a. Chief complaint
    b. Vital signs to include blood pressure, temperature, pulse rate, respiration rate, O2 saturation, height, and weight, BMI.
    c. History of present illness
    d. Review of systems as warranted
    e. Physical examination to include physical findings, lab data, etc.
    f. Assessment and care plan
    g. Orders
    h. Education and follow up

3. The following guidelines must be adhered to when documenting in the medical record:
    A. Two forms of identification must be present on every form or document that is either printed from or scanned into the electronic patient chart.
    B. A complete date (month/ day/year), time, and staff initials must be entered for every notation.
    C. Late entries, corrections and/or addendums are to be noted as such.
    D. When a translator is used during a patient visit, a note will be made in the chart stating a translator was used and the name of the interpreter. (see GSA 5.17.2 Translation Policy).
    E. When a chaperone is used during a patient visit, a note will be made in the chart stating a chaperone was used and the name of the chaperone. (see GSA 5.17.3 Chaperone Policy).

The patient medical record is a legal document that must not be altered or falsified.