Physician Documentation for Hospital In-Patients Policy

Summary of Changes

	NEW	Previous
BC Cancer		HIM 060-IV-30 - Physician Documentation for Hospital In Patients – last approved on March 2, 2013

1. Introduction

1.1 Purpose

1.1.1. To provide a policy to guide physicians about what documentation is required for Hospital In- patients.

1.2 Scope

1.2.1. The Medical Staff Professional Rules and Regulations will determine the specific policy requirements for documentation.

2.0 Policy

2.1. A History and Physical will be performed and recorded within 24 hours of admission.

2.2. The written record must be sufficient to substantiate the rationale of hospital admission, and the treatment prescribed.

2.3. The Progress Notes will record all investigational findings, treatment plans and changes of clinical status and will be appended daily.

2.4. A Discharge Summary will be dictated within 24 hours of discharge (whenever possible), and must be completed within 2 days.

3.0 Responsibilities and Compliance

The patient's attending physician will be responsible for documentation and may delegate this responsibility to the medical trainees under supervision, or Clinical Practitioners in oncology.

Anyone admitting a patient is required to comply with this policy.

4.0 References

H:\EVERYONE\MedicalStaff\Policy Reference Documents\MEDICAL STAFF RULES_PHSA_BD (Feb 5.09).pdf

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Approving Body:	Medical Advisory Committee		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	Dr. Lorna Weir	Chair Medical Advosory Committee	18-10-2018
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	Clinical Records Committee		
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