

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

Released:	29/Oct/2018	Next Review:	24/Jul/2021	
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Physician Documentation for Hospital In-Patients Policy

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

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

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First Issued:	last revised Mar 16 13		
Approving Body:	Medical Advisory Committee		
Final Sign Off:	Name	Title	Date Signed
	Dr. Lorna Weir	Chair Medical Advosory Committee	18-10-2018
Developed By:	Name	Dept.	но
	Clinical Records Committee		
Owner(s):	Clinical Records Committee		
	and Medical Advisory Committee		
	Committee		
Posted Date:	29-10-2018		
Version:			
Revision:	Name of Reviser	Description	Date
	Clinical Records Committee		24-07-2018
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