Physician Documentation for Day Care Patients Policy

Summary of Changes

	NEW	Previous
BC Cancer		HIM 060-IV-40 - Physician Documentation for Day Care Patients– last approved on May 16, 2013

1. Introduction

1.1 Purpose

1.1.1. To provide a policy to guide physicians about what documentation is required for Day Care 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 note will be made in the chart documenting procedures for all patients admitted to the Daycare Unit, including fully-admitted patients and patients referred only for a specific procedure.

2.2. The note for the chart will be documented by the individual of the assisting resident/fellow performing the principal procedure for which the patient was admitted,

2.3. The note will be documented immediately following the procedure (including radiation treatment).

2.4. The note will serve as the Admission and Discharge Summary for Daycare Unit admission.

3.0 Responsibilities and Compliance

Procedures performed by a physician will be dictated by the physician or the assisting resident / fellow. (With the exception of needle aspirate biopsies which are documented in the actual report).

Procedures performed exclusively by nursing staff on the basis of pre-written orders (blood transfusions, for example), will be documented by the nurse on nursing forms.

Anyone performing a procedure 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, MAC	18-10-2018
Developed By:	**Name**	**Dept.**	**HO**
	Clinical Records Committee		
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