1.4.22 Medical Provider Documentation Expectations

(a) Purpose

To ensure that medical providers document all relevant clinical encounters in a complete and timely manner while adhering to all organizational, federal, state, regulatory, and accreditation requirements. The health record is a medical legal document and where every effort shall be made for an accurate and timely record of the patient's condition, progress, and treatment plans.

(b) Responsibilities

(1) Statewide

The Deputy Director, Medical Services is responsible for the oversight, implementation, monitoring and evaluation of this procedure.

(2) Regional

The Regional Deputy Medical Executive is responsible for the oversight, implementation, monitoring and evaluation of this procedure at the subset of institutions within an assigned region.

(3) Institutional

The Chief Medical Executive, or designee, is responsible for ensuring that medical physicians, Nurse Practitioners, and Physician Assistants understand and adhere to documentation expectations.

(c) Procedure

(1) Medical providers shall adhere to the following documentation requirements:

(A) Content and format of the health record shall be uniform, and medical providers shall use only approved California Department of Corrections and Rehabilitation (CDCR) documentation formats.

1. For patient safety reasons, abbreviations, acronyms, and symbols shall be used only when they are on the CCHCS approved list of abbreviations and symbols.
2. All documentation shall be entered electronically, except during Electronic Health Record System (EHRS) downtime procedures or when a particular process requires paper documentation. All paper documentation shall be legible so that patient safety is preserved when other health care staff are caring for the patient.
    a. Documentation shall be clear, concise, objective, reflect factual information, and shall serve to identify the patient, support and justify the provider's medical decision making regarding the patient's diagnosis, care, treatment, and services provided, as well as document the course of treatment and results.
    b. Documentation shall not be discourteous to other individuals and shall not include copies of administrative memos, administrative directives or emails, non-clinical information, or other information which is unrelated to the patient's care.
3. When using templates, care shall be taken to ensure the information entered is accurate and consistent.

(B) Frequency and Timeliness of documentation: To provide safe and efficient treatment for patients, all health care staff shall have timely access to health information.

1. Documentation shall be entered in the patient's medical record whenever the patient is assessed, evaluated, given education, or receives orders for diagnostic testing, medications or other treatment.
    a. This includes, but is not limited to, in-person and telemedicine clinic visits, inpatient admissions and rounding, Triage and Treatment Area (TTA) visits, on-call duties and in clinic co-consultations with a nurse.
    b. Documentation frequency in the inpatient setting is determined by Title 22 for Correctional Treatment Center (CTC) patients, except for the exemptions CDCR has obtained, and for Psychiatric Inpatient Program (PIP), and Skilled Nursing Facilities (SNFs). Documentation frequency is and as outlined by CCHCS leadership for medical providers seeing patients in Mental Health Crisis Bed (MHCB), and Outpatient Housing Unit (OHU) patients. Refer to Appendix 1, Documentation Frequency in Inpatient Settings.
2. Medical providers shall document in the medical record after the encounter. Specifically, documentation shall be completed, signed off, and submitted within the following timeframes:
    a. For in-person or telemedicine encounters, documentation is expected to be completed the day of the appointment but no later than the next calendar day.
    b. For inpatient rounding and on-site after hours encounters, documentation is expected to be completed the day of the encounter but no later than the next calendar day.

c. For on-call encounters done remotely, documentation shall be completed in the EHRS by the end of the next business day. (Health care staff shall have access to the onsite health care staff's documentation of the TTA visit, etc. to assist with ongoing management).
d. For patients admitted to a CTC, PIP, MHCB, OHU, SNF or hospice, an admitting History and Physical (H&P) shall be performed by a medical provider within 24 hours of admission.
e. In rare circumstances where timeframe extensions are needed, written supervisor approval is required.

3. Telephone and verbal orders shall be reviewed and signed within 48 hours excluding weekends and holidays. Orders placed weekends or holidays shall be reviewed and signed off the next business day.
4. Late Entry: When a pertinent medical record entry was missed or not written in a timely matter, the provider shall follow the requirements:
   a. Identify the new entry as a "late entry"
   b. Identify or refer to the date and circumstance for which the late entry is written.
   c. Enter the current date and time;
   d. The entry shall be signed.
   e. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.
5. Addendum: An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.
   a. In the EHRS the date, time, and author of the addendum is noted automatically and the addendum is flagged as part of the original note.

(C) Identification of Documentation: In order to allow clinical information to be located easily within the EHRS, providers shall ensure that their documentation is made in the appropriate area of the EHRS and that entries are labeled correctly and with as much specificity as possible.

1. Medical notes in the Documentation section of the EHRS are each assigned a note "Type" and a "Title".
   a. The note "Type" is selected using a drop-down menu and includes choices "History and Physical"," "Outpatient Progress Note", "Inpatient Progress Note", "Phone Message/Call" and "Procedure Note".
   b. The note "Title" is populated by choosing a "Note Template" from the selections offered. There are several choices of note templates that can be used including "Admission H&P", "Office Visit Note", "Progress/SOAP note", "Procedure Note", and "Free Text Note". The note "Title" can also be entered as free text and customized.
   c. Refer to Appendix 2, Examples of Encounter/Note Types, Titles and Templates for examples.
2. Ensuring, at minimum, that the note "Type" is correct shall assist other health care providers as they review the chart. For example:
   a. Note type "Outpatient Progress Note" would be used for Chronic Care and Episodic Care, while note type "Procedure Note" would be used when documenting a medical procedure. Refer to Appendix 2 for examples.
3. On – Call Documentation: On – call duties are done "on-site" at some institutions and by phone.
   a. The "on-site" call duties shall be documented utilizing note types "TTA Progress Note" or "Inpatient Progress Note" for rounding in inpatient areas.
   b. Phone on-call duties shall be documented using the "Phone Message/Call" note type.
   c. The medical provider shall record the assessment (or verbal assessment received), the actions taken, and the medical rationale for the actions taken. The on-call provider ensures any necessary follow up is ordered with the primary care provider (PCP).

(D) Other Documentation Expectations:

1. Voice-activated documentation systems (e.g., Dragon): Providers using these systems shall review the note, correct errors and omissions and sign the note to authenticate its accuracy. A blanket disclaimer regarding possible dictation errors does not absolve a provider from needing to proofread their dictated notes for accuracy and completeness.
2. Copy and paste guidelines: The "copy and paste" functionality available in the health record has the potential to eliminate duplication of effort and save time, however it is also easily abused and "Legacy charting" that is not carefully edited is a risk to patient safety.

a. Carefully review and "copy and paste" information: Any "copy and paste" functionality should be kept to a minimum and when used, the pasted information shall be carefully reviewed and edited to ensure up-to-date and accurate documentation. Ensure that the information pasted belongs to the correct patient.
b. Copy and paste from the provider's previous encounter: A provider may copy and paste entries made into the patient's record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.
c. Copying from another provider's entry: If a provider copies all or part of an entry made by another provider's source documentation, the provider using the copied entry becomes responsible for the accuracy of the other provider's source document. The source author's name should be included.
d. Copying test results and data: If a provider copies and pastes test results into an encounter note, the provider is responsible for ensuring the copied data is relevant and accurate.

3. Review of Diagnostic Tests and Labs: Providers shall indicate that they have reviewed and addressed diagnostic reports by initialing and dating each report (when presented with a hard copy) or by electronically endorsing each report through the approved EHRS workflows. Refer to the Health Care Department Operations Manual (HCDOM), Sections 3.1.13, Medical Imaging Services, and 3.1.14, Laboratory Services.
   a. Per policy, the provider creates a patient letter, which is sent to the patient.
   b. If clinically indicated the provider shall create a plan of care that addresses any abnormal test results and document this plan in the health record.
4. Effective Communication: Providers shall document validation that effective communication was provided when required by policy. Refer to the HCDOM, Section 2.1.2, Effective Documentation.

Appendices

- Appendix 1: Documentation Frequency in Inpatient Settings
- Appendix 2: Examples of Encounter/Note Types, Titles and Templates

References

- California Business & Professions Code, Section 2266; California Code of Regulations, Title 22, Division 5, Chapter 9, Article 4, Section 77139, Health Record Service; Section 77141, Health Record Content; and Section 77143, Health Record Availability
- American Health Information Management Association (AHIMA):
  - *Health Information Management Concepts, Principles, and Practice*, Chapter 3, Documentation Standards, Pages 91-93; Chapter 8, Paper-based and Hybrid Health Records, and Incomplete Record Control, Pages 212- 215 (Third ed., 2010)
  - *Documentation for Ambulatory Care*, General Documentation Guidelines (Revised ed., 2001)
  - *Update: Maintaining a Legally Sound Health Record – Paper and Electronic,* Journal ofAHIMA 76, No. 10, 64A-L (Nov-Dec 2005)
- Medical Provider Rounding and Documentation – Specialized Health Care Housing Memorandum June 27, 2022
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.2, Effective Communication
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.13, Medical Imaging Services
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.14, Laboratory Services

Revision History
Effective: 05/12/2023
Revised: 11/22/2023

Appendix 1
Documentation Frequency in Inpatient Settings

Medical Correctional Treatment Center (CTC)			
Inpatient Setting	**Frequency**	**Inpatient Setting**	**Frequency**
Initial H&P	Within 24 hours	Frequency of clinical encounter and chart note once patient is stable, during the first month post admission	At least every seven calendar days, more frequently as clinically indicated
Frequency of clinical encounter and chart note if patient is not stable	At least every three calendar days	Frequency of clinical encounter and chart note if patient remains stable, after first month post admission	At least every 14 calendar days, more frequently as clinically indicated
Outpatient Housing Unit (OHU)			
Inpatient Setting	**Frequency**	**Inpatient Setting**	**Frequency**
Initial H&P	Within 24 hours	Additional episodic care	As clinically indicated
Routine clinical encounter and chart note frequency	At least every 30 calendar days	Encounters following medical/surgical specialty appointments	Per outpatient policy
Psychiatric inpatient Program (PIP) and Mental Health Crisis Bed (MHCB)			
Inpatient Setting	**Frequency**	**Inpatient Setting**	**Frequency**
Initial H&P	Within 24 hours	Additional episodic care	Encounters following medical/surgical specialty appointments
Routine clinical encounter and chart note frequency	At least every 30 calendar days	Encounters following medical/surgical specialty appointments	Per outpatient policy

Appendix 2

Examples of Encounter/Note Types, Titles and Templates

Encounter Type	EHRS Note Type	Title (designated by Note Template chosen)
Chronic Care Visit	Outpatient Progress Note	Multiple Note Templates can be chosen including: • Office Visit Note • Progress/SOAP note • Free Text Note For additional specificity providers can add detail to the title such as: "Office Visit Note Chronic Care DM" The Title can be entered completed as free text as well, such as: "CCP – MAT F/U, HTN"
Medical Episodic Visit 7362 F/U	Outpatient Progress Note	Multiple Note Templates as above can be chosen. Can add or free text additional information such as: "Progress/SOAP note abnormal lab follow – up". The Title can be entered completed as free text as well, such as: "7362 F/U rash and knee pain".
Co – Consultation	Outpatient Progress Note	Multiple Note Templates as above can be chosen. "Free text note" and Title: "Co – Consult 7362 rash" ii. PCP adds addendum to the Nursing documentation and co – signs the Nursing note.
Specialist phone calls/ emails Family Communication	Phone Message / Call	Typically, "Free Text Note" template is used. Additional detail can be added to Title such as: Free Text Note Specialist correspondence Free Text Note Family Communication
On-Call duties done on site	TTA Progress Note or Inpatient Progress Note	Multiple Note Templates can be chosen including: • Office Visit Note • Progress/SOAP note • Free Text Note
On-Call duties done remotely	Phone Message / Call	Note Templates often used is Free Text Note "Dot-phrase" available to pull in some information: [.oncall]
Procedure documentation	Procedure Note	Note Template "Procedure Note" Can add Title detail such as: Procedure Note Toenail removal

Encounter Type	EHRS Note Type	Title (designated by Note Template chosen)
TTA visit	TTA Progress Note	Multiple Note Templates can be chosen including: • Office Visit Note • Progress/SOAP note • Free Text Note Additional detail can be added to Title such as: Free Text Note TTA Abdomen pain
Inpatient documentation (including CTC, PIP, OHU)	Inpatient Progress Note	Multiple Note Templates can be chosen including: • Office Visit Note • Progress/SOAP note • Free Text Note Additional detail can be added to Title such as: "Progress/SOAP note CTC 7 day PCP" "Free Text Note PIP 30 day PCP"

Revision History:
Effective: 05/16/2023
Revised: 11/22/2023