Lenox Hill Hospital
Northwell Health℠

HEALTH INFORMATION MANAGEMENT DEPARTMENT

MEDICAL RECORD DOCUMENTATION

THE RULES OF DOCUMENTATION

- All hand-written entries must be made using a ballpoint, gel, or fountain pen; felt tips may bleed through the page.
- All entries must include the month, day, year and time of day they are made.
- All entries in the medical record must be signed with your name and PCN number.
- All entries must be legible.
- If an error is made in a note, it should be cleanly crossed out with a single line, dated, and initialed.
- Only Hospital-approved forms may be used in a patient's medical record.
- Use both sides of the page and be careful to document in sequence with the chart's chronology.
- In addition to the daily progress note, all of the following should be documented in the patient's medical record, even if they require multiple additional notes:
  - Physical examinations, including those done serially for specific concerns
  - Patient interactions of any kind
  - Family discussions, including identification of the persons involved
  - Interpretations of test results and other elements of the workup
  - Changes in treatment plans, e.g. starting a new medication or

discontinuing one, recommending or planning a procedure, requesting a consultation, etc.

- Progress notes should indicate that the patient was kept informed of his or her condition, as well as the treatment plan.
- Remember to document all instances of patient non-compliance or refusal of recommended treatment and what steps were taken to address this apparent conflict with the patient.

Following a patient's discharge, promptly complete the medical record in accordance with Hospital requirements to enable the Department of Health Information Management (HIM) to secure the patient record expeditiously and safely. If you are responsible for the discharge summary, complete it the same day as the patient's discharge while the case is fresh in your mind. Discharge summaries should be dictated using the Hospital's dictation system, available by dialing extension 4-2447 (212)-434-2447. The system will prompt you for the required information. The discharge summary will need to be signed in the Department of Health Information Management. Records that remain incomplete for more than 30 days after discharge are considered *delinquent*. Delinquent records create a series of problems that include delays in Hospital payment, increased risk of malpractice loss, and challenges to the Hospital's accreditation. Therefore, **do not contribute to the delinquent chart count**, which is closely monitored.

Medical records are the property of Lenox Hill Hospital and may NOT be removed from the Department of HIM without officially signing them out. Additionally, charts may NOT be removed from the Hospital premises, taken to House Staff on-call rooms, kept in desks, file drawers or locked in offices.

ABBREVIATIONS

To address the plethora of abbreviations that find their way into medical records, the Hospital subscribes to an on-line reference that provides interpretations of unknown or unfamiliar abbreviations. **Jablonski's Dictionary of Medical Acronyms & Abbreviations** is accessible through the following link: http://www.statref.com. In the upper left-hand corner of the page, enter the user name (metro11) and password (lenox), all in **lowercase**.

PROHIBITED ABBREVIATIONS

Because of the serious danger associated with their misinterpretation, the abbreviations listed below **are not approved** and **cannot be used** in any documentation related to medications at Lenox Hill Hospital. This prohibition includes

their use in orders, prescriptions, medication lists, medication reconciliation forms, discharge instructions, etc., and is not restricted to hand-written documents. To provide an even greater margin of safety, health care practitioners should avoid using these abbreviations in all documentation, except in those instances when greater precision is indicated by the use of a trailing zero (e.g. in pathology reports recording the size of a lesion). The Nursing and Pharmacy staff will not accept medication orders using these abbreviations.

Do Not Use	Acceptable form
qd or q.d. QD or Q.D.	"**daily**"
q.o.d. or qod Q.O.D. or QOD	"**every other day**"
U or u	"**units**"
IU	"**international units**" "**internat units**"
MS, $MS0_4$	"**morphine**"
$MgS0_4$	"**magnesium sulfate**" "**mag sulfate**"
MTX	"**methotrexate**"
µg	"**mcg**" or "**microgram**" or "**micro-gm**"
Trailing Zeros X.0	"**X mg**" [leave off the **.0**]
Naked Decimals **.**X mg	"**0.X mg**" [put a 0 before the decimal point]
DTO	**"deodorized tincture of opium"**