OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 6: Patient Care **POLICY: 6.045**

SUBJECT: **Clinical Documentation**

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SUPERINTENDENT

DATE: JANUARY 30, 2012

I. POLICY

A. Clinicians in each discipline shall complete and document required assessments and progress notes per the attached table (Attachment 1).

B. A patient's medical record is a confidential report maintained for purposes of communication, accountability, and coordination of care and services provided to a patient by all disciplines. It references significant patient specific events, includes staff interventions and observations regarding patient response to interventions, and records progress related to individual Treatment Care Plan (TCP) goals.

C. Clinical findings and observations shall be recorded clearly, concisely and in a timely manner in the patient's electronic medical record or on the appropriate form. Unless otherwise specified in the attached table, the frequency of progress notes is based on the rate of anticipated change in the patient's condition and the frequency with which services are delivered.

II. PROCEDURES

A. All documentation shall be entered into the appropriate section of the electronic medical record or be written on the appropriate form. Handwritten notes shall be in chronological order and include the date and time the note was written. The (legible) name and credentials of the clinician making a handwritten entry shall be included.

B. When documenting in the electronic medical record, select the patient and the appropriate section in which to document. Enter note, review draft, make any required modifications and finalize the entry.

C. When a co-signature is required, such as for students, interns, or residents, the supervising clinician shall append the document as follows:

1. Open Avatar CWS
2. Select "Document Routing"
3. Select "Append Document"
4. Select the appropriate patient
5. Select date and document to be appended
6. Review the student/intern/resident note
7. If complete and accurate, make a note to that effect. If not, correct the discrepancy and accept the change

D. Handwritten entries in the patient's medical record shall be written in blue or black ink.

E. Only OSH-approved abbreviations are to be used.

F. Proper spelling, grammar, and military time shall be used.

G. Clearly identify when care has been rendered by another member of the health care team.

H. Ensure that all entries are complete and that blank spaces on forms are lined out.

I. Late entries shall be clearly identified and reference the actual date and time of the event or observation.

J. For non-physicians, the BIO-R format shall be utilized to organize the contents of behaviorally oriented discipline notes.

B = Behavior	Describes what the patient said or did relative to a specific problem or treatment goal.
I = Intervention	Describes the services/interventions delivered relative to a specific problem or treatment goal.
O = Observation	Describes the patient's response to a specific service/intervention.
R = Recommendation	Describes recommended action/intervention relative to a specific problem or treatment goal.

K. For psychiatrists and psychiatric Nurse Practitioners, SOAP format shall be used for all monthly summary notes within Avatar. The Avatar template for

monthly psychiatric and psychiatric Nurse Practitioner notes is set up in SOAP format. All other physician notes may be written in either SOAP or narrative style.

S= Subjective	Describes what the patient said or did relative to a specific service or intervention. This usually includes a direct quote.
O = Objective	Describes observations of the patient's behavior, usually while participating in a service or intervention.
A = Assessment	Describes the interpretation of the meaning of the patient's response to a service/intervention.
P = Plan	Describes what services/interventions should be provided next, and may include recommendations for changes to the patient's Treatment Care Plan.

III. ATTACHMENTS

Attachment A - Oregon State Hospital Treatment Manual Documentation Standards

Attachment B – Required Psychological Assessments by Commit Type

IV. REFERENCES

The Joint Commission, Comprehensive Accreditation Manual for Hospitals
CMS Standards, 42 CFR 482, Subchapter E, Conditions of Participation for Hospitals
OSH Medical Department Policies/Procedures:
- 1.001, Initial Documentation by Physicians

OSH Nursing Service Department Policies/Procedures:
- Nursing Assessment Admission
- Alert Charting, Documentation
- Nursing Monthly/Weekly Summary, Documentation
- Documentation, Progress Notes
- Documentation: Discharge
- Multipurpose Flow Sheet
- Critical and/or Stat Lab Values – Communication, Documentation

Avatar Training Manual

Replaces Oregon State Hospital Policy and Procedure 6.045, *Clinical Documentation*, dated 12/15/2010.

OREGON STATE HOSPITAL TREATMENT MANUAL DOCUMENTATION STANDARDS

ASSESSMENT TIMELINE								
	1st day	**72 hours**	**10th day**	**1st 30 days**	**1st 60 days**	**1st 90 days**	**Q 90 days**	**1st 6 months**
Interdisciplinary Team		Initial Treatment Care Plan	Update TCP	Update TCP START & ISURF	Update TCP	Update TCP	START Reassess	Update Plan monthly
Physician	Admit note							AIMS Q 6 months
Rehabilitation Services			Initial					
Vocational/Education Services				As referred				
Psychologist			PAN		IPA	VRA		
Registered Nurse	Within 4 hours							
Social Worker			Psychosocial					
Language & Diversity Services		Assessment		As referred				
Others (Dietitians, Spiritual Svs, etc.)				As referred				

PROGRESS NOTE TIMELINE					
	Per Shift	**Per Week**	**Per Month**	**Other- Discipline Specific**	**Annual**
IDT Review Note		First 60 days, all disciplines listed on TCP write notes (Group notes count-RSD only). MDs utilize SOAP or approved format. All other disciplines use BIOR or approved format. PRS MHTs need not chart if RN charts.	After 60 days, all disciplines listed on TCP write progress notes, at minimum, on a monthly basis. All disciplines document more frequently if significant event or change has occurred. (Weekly group notes meet and exceed this standard.)		Annual reassessment required of all disciplines listed on TCP, unless reassessment completed more frequently.
Physician					
RSD/Vocational Education Services					
RSD-Individual treatment & patients in GTS seen in on-unit treatment				PRN- at time of service	
RSD-IDT note if unable to attend or verbal summary for IDT note					
Psychologist/ Mental Health Specialist				Time of service -BIOR format,	
Registered Nurse	For 72°			PRN	
Mental Health Therapist				PRN	
Social Work				PRN & D/C Progress Summary Note	
Treatment Mall- all disciplines				PRN – at time of Service	

OREGON STATE HOSPITAL

Required Psychological Assessments by Commit Type

	PSRB	370	Civil	Gero
ISURF	Y	N	N	PSRB Only
VRA	Y	N	As Rx	PSRB Only
IPA	Y	As Rx	As Rx	PSRB Only
START	Y	N	Y	PSRB Only
PAN	Y	Y	Y	Y