WEISMAN CHILDREN'S REHABILITATION HOSPITAL (WCRH)
OUTPATIENT REHAB SERVICES MANUAL

SUBJECT: DOCUMENTATION - GENERAL GUIDELINES No.: 1000.00

EFFECTIVE DATE: 9/23/99 Page 1 of 2
REVIEW/REVISE: 12/15/04, 12/04/05, 1/9/06, 01/08/07, 01/24/08, 01/25/09, 7/2010, 8/2011, 7/2012, 4/2015, 1/2018, 1/21

PURPOSE: To ensure that all documentation is consistent throughout the Outpatient Rehab Department of Weisman Children's Rehabilitation Hospital and Centers

POLICY: Medical record documentation is presented in an acceptable format with adherence to state regulations and WCRH guidelines.

PROCEDURE:

1) All documentation is completed utilizing the electronic medical record system.

2) All pages (both sides if 2 sided) must be identified with patient's name (last and first) and the patient's date of birth.

3) Identification of the specific type of documentation and department name must be noted.

4) Current date of documentation should be recorded.

5) Documentation should reflect specific clinical observation(s).

6) Billing is completed within the context of the electronic medical record system utilizing the appropriate CPT codes.

7) All entries are dated and electronically signed with the full staff person's full name and professional credentials/designation (as applicable).

8) All information must be factual and precise.

9) The mechanism to document an error in charting is to un-sign the note in the electronic medical record, provide the reason for un-signing the note and make the necessary correction. The correction should be authenticated when the user signs off on the note

electronically. The EMR maintains a log of these changes

10) Therapist countersignature is required for entries by certified/licensed assistants and student(s) as designated.

11) Only abbreviations found in Stedman's Book of Medical abbreviations may be used. Abbreviations located on the "do not use" list may not be included in any documentation.

12) Documentation of daily sessions must be completed within 24 hours of the visit. Daily note content will include:

A. Treatment goals (objective/measurable)
B. Patient performance/response to intervention
C. Update on patient progress
D. Patient/family teaching provide and family/child's ability to comprehend training
E. Date, Time, Length of Treatment Session, Signature, Credentials.
F. Pain level, pain scale used, intervention provided if necessary and response to treatment
G. Medical Tracking including up to date medications and any change in patient's condition or status

13) Initial Evaluation reports must be completed within 3 business days of the initial evaluation appointment.

14) Progress Evaluations and Discharge Summaries must be completed within 2 business days of the appointment.

15) All documentation must be signed off in the EMR within 3 business days of the month following when the appointment occurred.

16) Copies of the Initial Evaluations, Progress Evaluations and Discharge summaries shall be mailed to the physician, parent/guardian, insurance provider and other sources as identified in the chart and authorized by the parent/guardian

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Director of Outpatient Services Date Administrator Date