Guidelines for Respiratory Care Services Electronic Medical Record Documentation (EPIC)

Purpose

- To provide Respiratory Care Practitioners with guidelines for making entries into the electronic medical record.
- To improve patient care by ensuring that assessments and pertinent recommendations made by Respiratory Care Practitioners are documented in the electronic medical record and easily accessible to all health care professional involved in the patient's care.

Audience

Licensed Respiratory Care Practitioners employed by The University of Texas Medical Branch Respiratory Care Services Department.

Guidelines

Basic:

- Use correct Standard English (i.e. complete sentences, proper grammar and punctuation).
- Use only approved hospital abbreviations.
- Enter notations that are complete and concise.
- The medical record should not be used to dispute other health care professional's interpretations or opinions. Questions about the professional's notes or actions should be discussed personally with that individual.
- Statements made in the medical record should be objective, accurate and well supported.

Medical Record Entry:

Respiratory Care Practitioners shall make entries under the ‘MAR’, ‘Doc Flowsheet’ and ‘RCS Assessment’ sections of EPIC regarding the following:

- Performance of a therapeutic or diagnostic service.
- Administration of medication
- Replacement of equipment used in the delivery of a therapeutic or diagnostic procedure.
- Omission of therapy with a brief statement of why the therapy is missed.
- All entries pertaining to the care given and patient response and conditions will be completed.

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Guidelines

Medical Record Entry Continued:

- Entries into the electronic medical record shall conform to departmental charting standards for each therapeutic modality.
- Clinical affiliated students may or may not have 'view only' access to the electronic medical record. Entries made by students must be done so under the direct supervision of the assigned therapist and will be signed with that practitioner's name.

Progress Notes Entry:

Respiratory Care Practitioners shall make entries into the Progress Notes section of EPIC when any of the following conditions exist:

- A Respiratory Care Consultation has been requested.
- A special procedure is performed by the therapist (i.e. intubation, surfactant delivery)
- A clinically important event regarding a patient's respiratory condition or response to therapy occurs which is first noted by a therapist.
- Complex discharge and/or patient/family health education services have been performed

Progress Notes entries should be concerned with the following:

- Documentation of observations about the patient's respiratory clinical condition (symptoms and signs).
- Response/lack of response to therapy.
- Adverse reactions to treatment.
- Difficulty giving therapy.
- Patient/family response to therapy.
- Documentation and assessment of patient/family education.
- Documentation and assessment of discharge planning services.
- Recommendations concerning the patient's respiratory care based upon above.

Corresponding Policies

Institutional Handbook of Operating Procedures, Medical Record Documentation, Policy # 9.2.15
http://www.utmb.edu/policy/ihop/search/09%2D02%2D15.pdf

References

Plevak DJ, Ward JJ; In: Burton GG, Hodgkin JE, Ward JJ, Eds. Respiratory Care: A Guide to Clinical Practice. 4th edition Philadelphia: JB Lippincott; 1997.