Guidelines and Protocols

TITLE: EMERGENCY ROOM RECORD

PURPOSE:

To provide a legal written record of medical/nursing care rendered and the patient's response to that care during his/her emergency room visit.
To provide a means of communication between the healthcare professionals; as well as provide a mechanism to review, study and evaluate patient care.

PROCESS:

I. **EMERGENCY ROOM RECORD**

A. The Emergency Department Record (Policy # 4410) is confidential and shall be treated as such.

B. An Emergency Department Record shall be generated and completed on every patient registered in the Emergency Center(s). This record shall be incorporated into the patient's permanent hospital record. This record shall include the following information:

1. Patient Identification.
2. Patient's signature or designee for consent to examination/treatment.
3. Time and mode of arrival.
4. Allergies.
5. Immunization history of children and patients with open wounds.
6. Pertinent history of the illness or injury, including details relative to first aid or

Emergency care administered prior to his/her arrival to the Emergency Center.

7. Diagnostic and therapeutic procedures, including results and/or the patient's response.
8. Description of significant clinical, laboratory, and radiology findings.
9. Diagnosis.
10. Discharge instructions for follow-up care.
11. Disposition and the patient's condition upon completion of evaluation/treatment.

C. Ambulance transport records shall be made available to the physician and be placed with the Emergency Department Record as a permanent part of the patient's medical record.

D. Each element of the patient's emergency department record shall include the patient's identification number and name prior to submitting to the Medical Records Department for filing and processing.

E. The Emergency Department Record shall be authenticated by the practitioner who is responsible for its clinical accuracy.
   1. The physician/nurse shall legibly sign his/her name (first initial, last name), title and employee I.D. number after each entry.
   2. Each entry is to be dated and timed.

F. Patient care needs are assessed and reassessed as the patient's condition warrants based on responses to diagnostic and invasive procedures, pharmacotherapy, and psychosocial events.
   1. All presenting patients shall be assessed and prioritized by a registered nurse and assigned to an appropriate medical service.

2. A nursing assessment shall be obtained and documented on the appropriate record (i.e. ER Face Sheet, CPR Record, Trauma Flow Sheet/Narrator, Progress Notes, Psychiatric Nurse Assessment) at the discretion of the registered nurse.

G. NO BLOCK CHARTING (i.e., 7-3; 3-11; 11-7) is permitted. The time shall be recorded by each entry. The detail and frequency of chart entries relates to the needs and condition of the patient.

H. INTAKE and OUTPUT shall be maintained as medically ordered or documented at least once per shift.

I. Upon discharge, the physician/nurse shall be responsible for:
   1. Reviewing the record for completion
   2. Ascertaining that all prescribed medications have been given, and recording the patient's response to treatment/medication, as indicated
   3. Recording the appropriate dismissal code (i.e., Home, Expired, DNA, Transferred, Admitted)
   4. Recording the date/time of dismissal, and condition on discharge
   5. Authenticating the record in the appropriate areas as indicated.
   6. Recording in chart the patient and/or family member's receipt and verbalized understanding of After Visit Summary (AVS), prescription(s), etc.

J. Dispositions from the Emergency Centers are defined as follows:
   1. ADMIT

      To a Hospital inpatient unit

2. AMA

   Leaves Against Medical Advice

3. LEAVES WITHOUT BEING SEEN BY A PROVIDER (LWBS)
   Occurs when the patient leaves prior to treatment being rendered by the physician

4. LEAVES BEFORE TREATMENT COMPLETE (LBTC)

   Occurs when the patient leaves after treatment was initiated by the physician.

5. EXPIRED
   Patient expired during the ER visit, and prior to a disposition being made from the ER.

6. HOME

   Dismissed to home

7. REFERRED

   Patient is referred to a Harris Health System Ambulatory Care Clinic direct from Triage

8. TRANSFER

   Patient transferred to Harris Health System and/or non-Harris Health System facility for continuation of care.

9. REGISTRATION ERROR

   When the financial registration is NOT completed to generate a medical record number OR when a clerical error occurs.

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REFERENCE / BIBLIOGRAPHY:

OFFICE OF PRIMARY RESPONSIBILITY:

LYNDON B. JOHNSON HOSPITAL TRAUMA SERVICES

REVIEW / REVISION HISTORY

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
04/21/20	8	04/21/20	Trauma Committee
02/21/17	7	02/21/17	Trauma Committee
10/21/14	6	10/21/14	Trauma Committee
10/16/12	5	10/16/12	Trauma Committee
06/19/12	4	06/19/12	Trauma Committee
09/23/11	3	09/23/11	Trauma Committee
09/15/08	2	09/15/08	Trauma Services