Section:	Division of Nursing	**********	Index: 6160.077a
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HACKETTSTOWN COMMUNITY HOSPITAL

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MATERNAL SERVICES
(Scope)

TITLE: QS System Patient Record

PURPOSE: To outline the procedure to maintain a complete Medical Chart Record reflecting both mechanical and electronically recorded patient data during the intrapartum through recovery portion of the patient stay.

LEVEL OF RESPONSIBILITY: Childbirth Family Center Staff

CONTENT:	PROCEDURE STEPS:	KEY POINTS:
	1. A patient record will be maintained for each patient admitted to the Childbirth Family Center according to established Medical Records policies, procedures, and practices.	An admission note for each patient monitored in the QS system must state: Patient age, Gravida, Para, LMP, EDC, Sent to L&D for (name of test or procedure), Name of provider sending patient, and the Reason for the test, procedure.
	2. Computerized annotation entries will be used to document patient care as an alternative to using written narrative notes.	The computerized annotations are used whenever the patient is electronically monitored (during labor, NST, before scheduled Cesarean section)
	3. The QS computer application is programmed so that a printed record of system "Charts" will be generated automatically.	
	4. A complete copy of the Electronic Medical Record Data (systems charts) will be generated at the completion of the patient recovery period. Additional printing may be done as deemed appropriate by the clinical staff, Medical Records and/or Risk Management.	**Staff member who completes recovery period should print out QS notes beginning with patient's admission.** *During computer system downtime, the notes will be written on paper and the monitor strip will be paper. Annotate the monitor strip number in the nurses' notes.
	5. The generated system "Chart" records will be placed in the appropriate patient's record by the nurse or the Unit Secretary at the time that those chart records are generated.	
	6. At discharge, the patient record will be reviewed for completeness. Any electronic chart records that are outstanding will be manually selected and printed to complete chart deficiencies.	The completed patient record (Medical Record) will be sent to Medical Records according to established Medical Records policy, procedure and practice.