

# RESIDENT HANDBOOK

## SECTION III: TRAINING ENVIRONMENT

### MEDICAL RECORDS

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- I. The hospital or clinic medical record is more than written or electronic documentation of a patient's encounter with the health care system. It is a means of communication between members of the healthcare team, a legal document in legal proceedings, and an auditing tool for a variety of healthcare agencies and insurers. It is not an instrument for unfounded conjecture. The importance of clear, concise, impartial, and accurate recording of patient-physician encounters, analysis of findings, and articulation of treatment plans should be self-evident.
- II. The following issues should be considered when a resident writes/types or dictates a note in the medical record (history and physical, progress note, procedural note, etc.):
  - a. The use of physician supervision should be documented (i.e., whether the resident reviewed the patient with the attending, whether the attending was physically present during key portions of the patient encounter, etc.). While for billing purposes it is the attending's responsibility to provide such documentation, the resident's notes can provide important supporting evidence.
  - b. Procedure notes and documentation of informed consent are required for any invasive procedure (other than placement of a peripheral venous line, an arterial line, an oro- or nasogastric tube, a urinary catheter, or a rectal tube). An acceptable procedure note includes the procedure, indication, findings or post-procedure diagnosis, operators, and perioperative status or complications.
  - c. Assume the patient and/or a legal representative will read everything written.
  - d. Discharge planning begins upon admission and should be reflected in chart documentation.
  - e. Medical student notes should not be relied upon for documenting the patient's hospital course. It is expected that a licensed physician evaluates patients and documents the patient examination and assessment on a daily basis.
  - f. Any text copied and pasted within an electronic medical record should be reviewed for accuracy and applicability to the patient's current condition. Do not repeat information that is readily available elsewhere such as laboratory results, etc. or copy from other notes such as a consultation. Rather, refer to the appropriate data.
- III. Resident Responsibilities
  - a. History and physicals must be written on each patient admitted. Student notes cannot be the only admission note in the chart. Each hospital has its own history and physicals (H/P) dictation policy – residents must follow that policy.
  - b. Daily progress notes must be written, reflecting the course of the patient while in the hospital. Progress notes should document important changes, the rationale for changes in diagnosis, therapy, or any other information of assistance to other care providers.
  - c. Discharge summaries must be dictated at the time of discharge. Charts must be signed in a timely manner. All incomplete medical records are the responsibility of the resident.

- d. Verbal orders given while on-call must be signed by the resident giving the verbal order or a member of his/her team including the attending. Lists of unsigned verbal orders are provided to the Office of Graduate Medical Education (GME) by UMC and are tracked.
- e. Incomplete medical records are tracked by all hospitals as part of their Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements. It is a professional responsibility for all residents to promptly dictate and complete their medical records. Deficiencies in this task will be reflected in professionalism report cards or other professionalism monitoring tools. They are also linked to the “check-hold” process of hospital payments for resident services.

Approved by the Graduate Medical Education Committee (GMEC) April 2017