PALMETTO HEALTH MEDICAL EDUCATION

Health Information Management (Medical Records)

Effective:	July 1, 2018
Reviewed by GMEC:	February 13, 2018
Initial Approval by GMEC:	October 6, 1992

Two policies were combined into one here, with two sections. One is Inpatient and the next is Teaching Clinics.

Statement

The resident/fellow is responsible for the preparation of a complete, legible, and current medical record for each patient. The attending and resident/fellow are responsible for documenting and signing each patient encounter. Documentation shall be completed as quickly as possible to ensure continuity of patient care. The medical record will be delinquent if not completed within 15 days from the date of service.

Associated Policy(ies)

Corrective Action
Professionalism
PH HIM-Delinquent Records
PH Health Information Management Policy
PH HIM Physician Suspension PGR

Responsible Positions

(Title) Residents & Fellows
Program Directors
Program Coordinators
GME Office
HIM Director
Chief of Staff

Equipment Needed

None

Inpatient Records

Procedure Steps, Guidelines, Rules, or Reference

1. The resident/fellow will dictate or document via PowerNote all appropriate operative notes and discharge summaries and will sign all verbal orders and progress notes during the patient stay and within timelines specified in medical staff policies. The preference is for Residents to type or create their notes in the EMR. The resident/fellow will complete, sign, and forward all H&Ps, Consults,procedure notes, transfer summaries, discharge/death summaries to the attending for signature. Failure to do so will cause the document to be held as unauthenticated which requires manual intervention for release. Additionally, if a patient is discharged within 48 hours theresident/fellow must document the following in the final note:
    a. Final diagnosis and procedures performed
    b. Reason for hospitalization
    c. Care, significant findings, treatment, and services rendered
    d. Condition of patient on discharge
    e. Instructions to patient/family on physical activity, diet, medication and follow-•-up care

2. All PowerNote entries must be named/titled appropriately i.e., History and Physical, progress note etc.

3. After a patient is discharged and all essential reports are received and placed on the record, the resident/fellow shall complete the medical record within seven (7) days of discharge. All operative notes must be documented within 48 hours. If the reports are still incomplete at the end of this period, the attending physician will be assigned, for completion. The record will be considered delinquent if the operative report isincomplete after 48 hours and the discharge summary is incomplete after 15 days.

4. The ability to admit and treat patients under the supervision of the attending may be suspended upon the above notification. Suspension will be automatically rescinded upon completion of the delinquent medical records.

5. A resident/fellow on the delinquent list six (6) times during the academic year could have his/her ability to admit and treat patients under the supervision of the attending suspended, and must submit a written justification for these delinquencies to the appropriate Chair, the DIO, the Director of Health Information Management, and the Chief of Staff.

6. Further delinquency will result in the revocation of moonlighting privileges, probation, or suspension. In addition, a notation concerning the above will go into the resident/fellow's permanent record and will be referred to in correspondence requested by other organizations and/or employers.

7. It is the responsibility of the resident/fellow to notify the Health Information Management Department upon completion of any delinquent charts.

8. Any resident/fellow who cannot complete his/her medical records (due to vacation, long-term illness, or educational leave) must notify the Health Information Management Department and the appropriate Chair.

9. Medical records not completed by the resident/fellow for any reason will be the responsibility of the resident/fellow's attending physician at the time of patient discharge.

Teaching Clinic Records

Procedure Steps, Guidelines, Rules, or Reference

1. Whether a paper or electronic medical record system is used in the clinic, the nurse, medical student and/or resident/fellow portion of the clinic record must be completed timely and signedwithin 7 days of the service date. After signature by the resident/fellow, the record must then be forwarded to the attending who was supervising in the clinic on the service date.

2. The attending must review the nurse, medical student, and/or resident/fellow entries in thepatient's record for accuracy and completeness, and sign the resident/fellow's record. When a separate attending note is required, the attending must complete their entry in the patient's record and sign it. The patient's record must be completed within 15 days of the service date.

3. The resident/fellow entry and signature in patient records and the subsequent attending entry (when required) and signature in-•-patient records will be monitored for delinquent medical records. See the Delinquent Medical Records policy in the appropriate manual/bylaws.

4. Medical records not completed by the resident/fellow for any reason will be the responsibility of the resident/fellow's attending physician at the time of patient encounter.

Additional Procedures for an Electronic Medical Record (EMR) system:

1. All providers (attendings, residents, medical students, nurses, etc.) practicing in a clinic are assigned a personal login and must create a personal secure password for use with the EMR system. Each provider's password must be kept secure and confidential.

2. Each provider is then assigned or creates a unique electronic signature code that is linked to their login. This personal signature code must be kept confidential and secure to ensure the integrity of the EMR system.

3. The unique signature code is entered to electronically sign a patient's medical encounter. The chart is annotated with the phrase "electronically signed by" along with the provider name, date and time.

4. When an EMR terminal is not in use, the terminal must be logged out or "parked" to protect patient confidentiality.