PALMETTO HEALTH
MEDICAL EDUCATION

Health Information Management (Medical Records) For Inpatients

Effective:	July 1, 2016
Reviewed by GMEC:	June 14, 2016
Initial Approval by GMEC:	October 6, 1992

Statement
The resident/fellow is responsible for the preparation of a complete, legible, and current medical record for each patient.

Associated Policy(ies)
Corrective Action
Professionalism

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

Equipment Needed
None

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 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 the resident/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. Effective September 1, 2013, 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. Effective September 1, 2013, 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 is incomplete 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 Suspension will be automatically rescinded upon completion of the delinquent medical records.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 Director of Education, 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 Director of Education.

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.

Signature on File
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