

LOYOLA MEDICINE
RESIDENT HANDBOOK
II. GENERAL INFORMATION

II. H. MEDICAL RECORD DOCUMENTATION

- H.1. The hospital or clinic medical record is more than written documentation of a patient's encounter with the health care system. It is a means of communication between members of the health care team, a legal document in legal proceedings, and an auditing tool for a variety of health care 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.
- H. 2. The following issues should be considered when a resident writes or dictates a note in the medical record (history and physical, progress note, procedural note, etc.):
1. 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.
 2. 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 oto- 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.
 3. Assume the patient and/or a legal representative will read everything written.
 4. Discharge planning begins upon admission and should be reflected in chart documentation.
 5. Medical student notes should not be relied upon for documenting the patient's hospital course. It is expected that a licensed physician evaluate patients and document the patient examination and assessment on a daily basis.
 6. Any text copied and pasted within the electronic medical record should be reviewed for accuracy and applicability to the patient's current condition.

GMEC Approved: September 7, 1995
Reviewed: September 7, 1995
Revised: March 2007