



Policy #11: Documentation of professional services in the Electronic Health Records

Residents will maintain accurate, comprehensive and timely records relating to all professional services rendered and/or recommended in accordance with Medical Staff Bylaws, Hospital policy and procedures and expectations as set by the Program.

- Professional services that require documentation in the Electronic Health Record include any encounter with a patient including virtual or telephone, records review, medical-decision making or prescription ordering. Co-signature is not required for re-ordering of prescriptions.
- Completion of chart notes is required by the end of the next business day and prior to leaving for personal time off (PTO). This will be monitored daily by preceptors who will review, co-sign, and provide feedback to residents regarding the quality of their notes.
- Notes which have not been completed within 3 business days of the professional service are considered delinquent and will be addressed by the Associate Program Director.
- Residents will address their EPIC in-basket daily. If they are unavailable to do so for any reason, they will arrange coverage.
- Residents are responsible for their paper inbox and must communicate with their team to ensure items are addressed in a timely manner.
- Inpatient medical record notes are reviewed by supervising residents as well as the on-service attending. Direct feedback is provided daily to residents regarding the quality and content of their documentation. The Associate Program Director receives a weekly report from the inpatient medical records office detailing incomplete medical record documentation and will take necessary steps to ensure appropriate, timely completion of documentation by the responsible resident.
- Vacation time and CME time will not be available to any resident until all chart notes are complete; and the semi-annual resident evaluation includes assessment of compliance with documentation standards. Persistent concerns regarding documentation compliance will be addressed with a resident by her/his team leader, the Associate Director, and/or the Program Director.

Residents will maintain the privacy and confidentiality of all patient information and records as required by Hospital policies and procedures and in compliance with all relevant state and federal laws and regulations, including, without limitation the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 and the regulations implemented and amended thereunder ("HIPAA").

Residents will comply with the Hospital's corporate compliance program and its efforts to detect and prevent health care fraud, abuse and waste.

Michael J Watson, MD
Program Director

4/30/2018
Date