RECORD KEEPING

I. MEDICAL RECORDS

Medical records are important legal documents which are being increasingly scrutinized by medical and non-medical personnel. The medical record should accurately reflect the events of the patient's inpatient or outpatient care and must be legible. Progress notes and orders should always be signed, timed and dated. Consistent with the policy of other departments in the College of Medicine, excessive delinquency will result in disciplinary action, so complete all medical records in a timely fashion.

II. GUIDELINES FOR DICTATION

Dictation of hospital charts is required within 48 hours after discharge. Dictation of operative notes must be done the same day of surgery. All dictations should include the date of the examination and/or procedure, the date of the dictation, and the name of the staff. The dictated operative report must state:

Attending Surgeon – Dr. Doe –

a. "Present and scrubbed throughout entire procedure"
b. “Present and scrubbed for vital portions of procedure”
c. “Available”

A. Discharge summaries must contain the diagnosis (primary and secondary), primary reason for admission, disposition and follow up plans.

B. All charts should be dictated prior to departure for vacation.

C. All charts must be completed before changing rotations.

D. Residents are responsible for proofing discharge summaries and operative notes. Your signature indicates approval of the document.

E. If any question about operative notes and/or dictations, check with the attending on the case for clarification. Unless told otherwise, proceed with the dictation.