



Stony Brook Medicine Graduate Medical Education

Subject: GME0021 Medical Records	Published Date: 04/29/2024
Graduate Medical Education	Next Review Date: 04/29/2027
Scope: SBM Stony Brook Campus	Original Creation Date: 11/18/2003

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Responsible Department/Division/Committee:

Graduate Medical Education Committee

Policy:

Stony Brook Medicine has established an institutional policy regarding the medical records system for the graduate medical education programs within the institution.

Definitions:

None

Procedures:

The medical record reflects the quality of patient care given in a hospital. The record is the basic tool for planning patient care and for communication between physicians and other persons contributing to patient care. The medical record must document the course of each patient's illness and care and must be available to the residents at all times. The medical records system must support the education of residents/fellows and provide a resource for quality improvement activities and scholarly activity.

Orientation regarding the institution's medical records systems is provided by the institution at resident/fellow orientation, and by the respective program. Medical record computer processes can be found in the Rules and Regulations of the Medical Staff Bylaws.

Rules and Regulations regarding Delinquent Records. Section 8 (SBUH Medical Staff Rules and Regulations):

No medical record shall be filed until it is complete, except on the order of the Medical Records committee.

Definition

A delinquent medical record is one that, more than 15 days after discharge, has not been completed with all required entries and documents.

Delinquent More Than 30 Days

If delinquency of a medical record results from 30 or more days of delay by an attending practitioner in completing a required part of the record, then that physician shall be subject to the following disciplinary action:

1. Attending practitioners shall have privileges suspended, except for emergency admissions, until the records are complete. Attending practitioners will not be able to admit, schedule patients other than current inpatients in the OR, Endoscopy Lab or Cardiac Cath Lab, but will be permitted to care for their current inpatients and perform previously scheduled procedures.
2. In all cases, the attending will be noted as the responsible party to dictate or complete operative reports and/or discharge summaries in the electronic Medical Record (EMR) and to sign those documents. Residents and fellows will not be included in the chart deficiency assignment and tracking process.
3. Suspensions for delinquent medical records shall be in accordance with the following.

Suspension Policy

If the discharge summary or operative report has not been completed within 15 days of discharge, The Health Information Management (HIM) department shall appropriately notify the practitioner that his/her privileges to admit patients shall be suspended 15 days from the date of notice. The Chief of Service and the OPPE designee will also be appropriately notified.

Practitioners will be appropriately notified of immediate suspension if any medical record remains delinquent after the warning period. The Chief of

Service, OPPE designee, Patient access services, OR Booking office and other necessary departments will also be appropriately notified.

Privileges will not be reinstated until all the delinquent records have been completed.

Resident/fellow Responsibility

Residents/fellows must enter appropriately detailed, accurate records of the care they provide to patients. This includes as appropriate:

- 1) Admission History and Physical Examinations
- 2) Daily Progress Notes
- 3) Procedure Notes
- 4) Notes regarding results of diagnostic studies, radiographic and pathologic findings
- 5) Discharge summaries
- 6) Admission and other orders, discharge orders
- 7) Medication reconciliation at admission, on transfer to another floor or service, and at discharge
- 8) Notes related to patient updates, complications, or unexpected events
- 9) Notes related to patient and family counseling and discussions

Failure to comply with record-keeping in a timely manner will be considered a lapse in professionalism, patient care, and interpersonal and communication skills. Repeated lapses in this area may place the resident under the pathway outlined in the "Substandard Resident Performance" policy.

Forms: (Ctrl-Click form name to view)

None

Policy Cross Reference: (Ctrl-Click policy name to view)

[SBUH Medical Staff Bylaws](#)

[SBUH Rules and Regulations](#)

Relevant Standards/Codes/Rules/Regulations/Statutes:

None

References and Resources:

None