GME – MEDICAL RECORDS – DEPARTMENT OF EDUCATION (DOE)

SCOPE:

Lehigh Valley Health Network (LVHN) adopts this policy for the following selected licensed entities:

- ☒ Lehigh Valley Hospital
- ☒ Lehigh Valley Hospital – Dickson City
- ☒ Lehigh Valley Hospital – Hazleton
- ☒ Lehigh Valley Hospital – Pocono
- ☒ Lehigh Valley Hospital – Schuylkill
- ☒ LVHN Children's Surgery Center
- ☒ LVHN Surgery Center – Tilghman
- ☒ Transitional Skilled Unit
- ☒ Lehigh Valley Home Care
- ☒ Lehigh Valley Hospice
- ☒ Lehigh Valley Home Care – Schuylkill
- ☒ Lehigh Valley Home Care – Hazleton

Medical and Dental Resident and Fellow Physicians
All ACGME and CODA approved postgraduate training programs at Lehigh Valley Health Network (LVHN).

LINKS TO ATTACHMENTS: N/A

LIST OF ASSOCIATED FORMS: N/A

DISCLAIMER:
This policy and the implementing procedures are intended to provide a description of recommended courses of action to comply with statutory or regulatory requirements and/or operational standards. It is recognized that there may be specific circumstances, not contemplated by laws or regulatory requirements that make compliance inappropriate. For advice in these circumstances, consult with the Departments of Risk Management and/or Legal Services, as appropriate.

REVIEW:
Origination: mm / yyyy
Review / Revision: mm / yyyy, mm / yyyy

Approved by: Joseph Patruno (Physician)	**Approval Date:** 04/11/2025
Version: 1	**Publication Date:** 04/11/2025
Original Creation Date: Not Set	**Next Review Date:** 04/11/2028

I. <u>PURPOSE</u>:

All documentation and medical reports (template or dictated) created by Residents the signature of the author and the responsible attending physician. This policy is to ensure the compliance of medical records by all residents (residents and fellows) in a manner and in the timeframe set forth by the Medical Staff Rules at Lehigh Valley Health Network (LVHN).

II. <u>SCOPE</u>:

Applicable to accredited or approved GME programs sponsored by LVHN.

III. <u>DEFINITIONS</u>:

Resident (graduate trainee; includes fellows) – A graduate of a medical, osteopathic and dental school holding the relevant professional degree (MD, DO, or DMD) and formally enrolled in an LVHN accredited or approved medical or dental graduate training program.

Medical Reports - History and Physicals, Discharge Summaries, Operative Reports, Procedure Notes, Consultations, Daily Progress Notes, and Emergency Department Notes.

Delinquent medical record – An incomplete medical record which remains assigned to a resident is expected to be completed and will be considered delinquent if not completed within medical staff timeframes.

ACGME – Accreditation Council for Graduate Medical Education

DIO – Designated Institutional Official

IV. <u>POLICY</u>:

Residents are expected to complete assigned medical records in accordance with medical staff guidelines and institutional and department requirements. LVHN, at the level of individual programs, will monitor residents' compliance with medical record requests.

V. <u>PROCEDURES</u>:

<u>Assignment of Medical Record Deficiencies:</u>

1. Most deficiencies are assigned automatically by Epic while the patient is in the inpatient setting to optimize the documentation process

    - Electronic assignment – deficiencies assigned by Epic or are automatically generated based on specific automated triggers / activities / events.

    - Manual assignment – entered or modified deficiency by an individual.

2. Records of discharged patients are reviewed by the Health Information Management (HIM) Department for quantitative deficiencies (i.e., documented discharge summaries, operative/procedure reports, histories and physical signatures) and may require edits or additions as determined.

3. If deficiencies are noted, the record is assigned to the resident physician responsible according to the information recorded in the medical record.

Time Frame for Chart Completion:

1. The medical record is available to the resident physician for chart completion online.

2. All documentation and medical reports will be authenticated by the author who created the documentation.

3. All documentation and medical reports created by a Resident will require the attending physician authentication within the report type timeframe listed below:

Report Type	**Report Signature Timelines**
History and Physical	24 hours after admission
Discharge Summary	48 hours after discharge
Operative Report	An operative report shall be entered immediately after the procedure and before the patient is transferred to the next level of care. Brief operative note is required if the full report cannot be documented prior to the transfer to the next level of care. Full report within 24 hours after surgery
Progress Notes	7 days
Consultation	7 days
ED Provider Note	• 4 days after discharge from ED • 24 hours if admitted

4. Documentation created in Epic that is not authenticated by the author will remain in an “incomplete” note status until the documentation is authenticated (My Incomplete Notes folder).

Monitoring System for Chart Completion Compliance:

1. The Epic system generates a suspension warning notice weekly which is sent to the residents' in-basket. – Residency program leadership are expected to monitor the resident's compliance with charting and enforce compliance in the completion of medical records.

2. In situations where trainees are non-compliant in completing medical records program leadership will be alerted to reconcile the situation.

3. The DIO and the Office of GME will be available to assist in circumstances where trainees demonstrate consistent or persistent non-compliance in their management of medical records.

4. Any resident physician found to be consistently noncompliant with chart completion requirements will be discussed by the office of GME with the Program Director to determine additional disciplinary action.

5. The disciplinary process will follow the Due Process policy.

Guidelines for Medical Records Holds

1. In the event of a resident physician's illness, records will not be counted as delinquent if the Health Information Management Department is promptly notified.

2. Notices of vacation must be sent in advance, in writing, to the Health Information Management Department to avoid having delinquent records and the accompanying reprimands levied.

3. Residents are expected to set their out of office dates in Epic for PTO, CME, seminar, or LOA or they can notify the HIM Department at 484- 884-5388. Resident deficiencies will be placed on hold until the resident returns at which time they are expected to be completed.

4. Graduating trainees will be audited and should they have incomplete records at the end of their training will not graduate nor be awarded a diploma until all records are appropriately completed.