GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V. 3
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: MEDICAL RECORDS

I. PURPOSE

To establish guidelines for the prompt and accurate completion of medical records.

II. SCOPE

This guideline applies to all medical records and all housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. 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 housestaff at all times. The medical records system must support the education of housestaff and quality assurance activities and provide a resource for scholarly activity.

B. Records for which the housestaff are responsible must be completed and discharge summaries dictated on the day of or immediately after discharge.

C. Notification by the Hospital’s Medical Records Department is sent to each department indicating delinquent charts. These charts must be addressed immediately by housestaff. (Delinquencies in chart completion may result in disciplinary action.)

D. Housestaff should familiarize themselves with departmental and hospital-specific or site-specific procedures for prompt completion of medical records and the sanctions which result if they are not completed in a timely fashion.

E. The Medical Records Committee at each major affiliate institution must have a resident representative.

Approved by GMEC on 2/23/99