Documentation in the Electronic Health Record

The Electronic Health Record (EHR) has become an important component of documentation of the medical record. The EHR enables the physician to have access to medical information in an immediate and comprehensive fashion, and enhances the quality of patient care. This policy defines the manner in which the EHR must be used within the residency program.

A. All policies relating to confidentiality and patient medical records or health information apply to use of the EHR. This includes both HIPAA and policies regarding confidentiality and patient information that are specific to the respective teaching institution.

B. Resident physicians admitting a patient must enter a comprehensive admission note that includes an appropriate history, physical examination, and evidence of medical decision making. This note must be completed within 24 hours of admission of the patient.

C. Progress notes must be entered on a daily basis for each patient admitted to the inpatient service.

D. The use of "cut and paste" is permissible under the following conditions:

    1. Past Medical History, Past Surgical History, Family History, and Social History may be taken from another note and cut and pasted into a note. The information must still be independently reviewed with the patient and/or his or her family, and attribution to the source of the information must be provided in the note.

    2. Templates for medications, when available, and lab or test results may be introduced into the note in the EHR. However, routine use of templates in daily progress notes is to be discouraged. The use of templates must always be considered in light of whether the template contributes to, or detracts from, the clarity of the communication in the note.

    3. The Assessment and Plan, or Problem List, may be inserted into a progress note using cut and paste under the following circumstances:

        a. This may be done only on daily progress notes when a resident is providing coverage for another resident's patients, and then only in order to ensure that nothing is inadvertently missed.

        b. This must never be done on an initial admission note.

c. Insertion of another resident's assessment and plan in a daily progress note must include attribution and the note ***must*** be updated and reflect the patient's condition that day and include any changes in the diagnostic and/or therapeutic plan.

E. The use of "cut and paste" is never allowed under the following circumstances:

a. The History of Present Illness (HPI), Review of Systems, and Physical Examination must always be an independent work product obtained by the physician and entered independently into the note. These elements must never be cut and pasted from another note.

b. The Assessment and Plan on an initial admission note, whether written by a first year resident, senior resident, or staff physician, must never be cut and pasted into another note.

c. The last note from the patient's previous admission must never be used as the initial note for the next admission.

F. Any concerns or questions regarding this policy shall be directed to the Program Director or to the Site Director of each respective teaching hospital. Failure to comply with this policy could result in disciplinary action to be determined by the Program Director according to the rules and guidelines in the Resident Handbook.

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