

EPIC Update: New Documentation Rules

The Medical Staff Bylaws now require all physicians to utilize the electronic medical record for all patient care documentation.

Below is a summary of the EMR requirements that have been incorporated into the Rules and Regulations Manual.

HISTORY AND PHYSICAL

1. A history and physical must be completed for every inpatient admission using the H&P note type in EPIC.
2. If a consult was completed in the Emergency Department immediately prior to admission, that consult note may serve as the admission H&P, but the user must enter a reference note in the H&P section as a placeholder.
3. The attending physician must authenticate the H&P note within 24 hours of the admission.
4. If the patient is admitted from the operating room, the pre-operative H&P may serve as the history and physical for the admission. This document will remain in the paper chart until discharge when it is scanned into the electronic record.

DISCHARGE SUMMARY

1. The discharge summary must be completed for all inpatients using the standard template provided in EPIC.
2. A hospital course narrative is required for those patients staying more than 48 hours and/or those with complications.
3. The discharge summary must be complete within 48 hours of discharge.
4. The responsible attending physician must authenticate the discharge summary.
 - a. For medical patients, the responsible attending is determined based on the attending on service at the time of discharge.
 - b. For surgical patients, the responsible attending is the surgeon named on the operative report. If a patient does not have surgery then the responsible attending is the admitting surgeon.

CONSULT NOTES

1. The consult note type should be used for all new and follow-up documentation for inpatient and Emergency Department consultations.
2. The supervising attending physician must cosign all consult notes. This applies even to consults performed in the Emergency Department where the attending may not have been present for the consultation.

OPERATIVE NOTES

1. An operative note is required for any surgical procedure performed on a patient.
2. Operative notes may be dictated through Medquist or entered directly into EPIC using the procedure note type.
3. Those notes dictated through Medquist must be authenticated within Streamline Health.

If a physician does not comply with use of the EMR for ALL patient care documentation he/she is subject to suspension by the Chief Medical Officer and the President of the Medical Staff.

If you have any questions please contact:

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