# Inpatient Medical Records

Learning to maintain timely, accurate, and legally appropriate medical records is an objective of residency training. Essentris and the successor inpatient electronic medical record MHS GENESIS provide pre-templated pediatric forms that can be used for a variety of functions. It is required that:

- An intern and a supervisory resident note will be in the chart within 24 hours of every admission.
- An assessment and plan will be written for each problem identified during the history and physical exam. The assessment should include the differential diagnosis and the plan should include steps taken to confirm the diagnosis and treat the problem.
    - At the end of each history and physical form completed by the intern, it should state, "the case was discussed with the attending who agrees with assessment and plan."
- The interns will write daily progress notes documenting progress, assessment and plans.
- If deemed important for safe transition of care of especially complex patients, the interns write off-service notes summarizing the problems, the work-up to date, the current assessment and projected plans.
- The interns write timely, concise discharge progress notes that indicate condition of the patient at discharge, discharge medications, and follow up plans.
- Any time you see a patient on call, you should write a progress note outlining the problem, findings, studies, assessment and plan. You should also verbally communicate this information to the team the next day.
- All procedures deserve a procedure note with indications for the procedure, discussion with the patient/parents about the procedure, consent form if indicated, findings from the procedure, and assessment and plans.
- Discharge summaries will be prepared by the designated house officer and should contain the details of the patient's illness that will be important in following that patient after discharge.
- The supervisory resident and attending should review and critique admission notes, progress notes, off-service notes and discharge summaries.
- The medical record is not the place to record arguments; if you are concerned about how to write about a particular issue, discuss it with your supervisory resident or attending first.

*Updated May 2020*