Policy for Clinical Student Documentation in the Medical Record

(adopted March 2010)

1. Introduction
    a. All clinical (M-3 and M-4) students are expected to document their evaluation of the patient in the patient's medical record.
    b. Student medical record documentation should comply with the current and applicable payer regulations.

2. Standards
    a. The medical record should document pertinent historical, physical exam, laboratory and radiological results, assessment and care plans for the patient.
    b. The medical record serves as a means of communication between healthcare workers including students and teaching physicians.
    c. The collection of data within the medical record may be useful for the education of the student.
    d. Documentation must be consistent with contractual obligations of payers.
    e. The date of the entry and a written or electronic signature are required on every entry to the medical record.
    f. Corrections to the medical record must be clearly and accurately documented to maintain the integrity of the record and to avoid the appearance of tampering.
        i. Corrections to a student's entry must be clearly documented by maintaining the readability of the original entry and providing the corrected information. Corrections should be dated and initialed (written or electronic) by the note's editor.
    g. Student performance of a billable service must be performed in the physical presence of a teaching physician or resident.
        i. Students cannot be used as scribes as this does not contribute to the education of the medical student.
        ii. If a student documents a billable service, the teaching physician must verify and re-document that service.
            1. Reference to the student's note is limited to the past medical history, family and social history, and the review of systems.
            2. The teaching physician must document the history of present illness, physical exam, assessment and plan in his/her note.
                a. Copy and paste of the student's note into the teaching physician's note is not permitted.
        iii. The teaching physician must be physically present for the entire billable procedure performed by a student.
3. Process
    a. Students should have full viewing rights to the medical records of those patients they are assigned.
    b. Students should see and document their findings, assessment and plans on all assigned patients on a daily basis.
    c. Templates may be used by students.
        i. Each discipline may develop a student template.
        ii. Students may use the general admission template (EPIC system).
    d. The student's note will be documented as separate from the attending or resident.
        i. When electronic medical records are utilized, students will be assigned a unique username and password. Entries will only be made utilizing the student's username.
        ii. Only the attending physician's note will be utilized for billing purposes.

iii. It is recommended that disclaimer should be added to all cosigned notes by the resident or attending which states: “Student documentation is for educational purposes only. The content of this note is not utilized to guide patient care. This note has been reviewed and feedback has will be provided to the student.”

e. Teaching physicians or residents should review the student’s note for accuracy.
    i. Responsibility for cosigning the note.
        1. Students assigned to the residents should have residents cosign their notes unless the service indicates otherwise.
        2. Students working directly under an attending should have the attending cosign the student’s note.
    ii. Feedback should be provided to the student either verbally or in writing.
    iii. Corrections (errors or omissions) should be appropriately documented by the reviewing the physician.
f. Student can update problem lists, educate patients, and gather information from consultants.
g. Student may not finalize orders.
    i. All student orders should be identified as “orders pending”.