

	Trauma Services	No. 4060
	Title: Physician Medical Record Documentation- Shared	Page: 1 of 1 Effective Date: 05/30/2023

PURPOSE:

Documentation of patient care will be completed per medical staff rules.

POLICY STATEMENT:

All aspects of patient care from procedures, to patient progress, to consults will be documented appropriately in the electronic medical records.

ENTITIES AFFECTED BY THIS POLICY (SCOPE):

This policy applies to the General Surgery Raleigh and Cary.

WHO SHOULD READ THIS POLICY:

This policy shall be read by department supervisors, managers, directors, and administrators. Furthermore, any individual considering issuing, revising, assisting in the drafting of, or archiving a policy.

PROCEDURES:

- I. The Emergency Department Physician, Emergency Department Resident, Trauma Attending/Trauma Resident/Trauma Advanced Practice Providers/Consultants will document their involvement in the care of the trauma patient and patient response to treatment in the electronic medical record.
- II. Tertiary Exams:
 - a. Raleigh- For trauma activations, a tertiary survey will be performed by trauma service's personnel to evaluate for missed injuries within 24-48 hours of admission. For activations without injuries the tertiary survey may be deferred at the evaluating trauma service attending's discretion.
 - i. If the patient is in the ICU the tertiary can be deferred till the patient is able to fully participate.
 - b. Cary- All trauma activations will receive a tertiary survey by a trauma service's personnel to evaluate for missed injuries within 24-48 hours of admission.
- III. Operative interventions are documented on the patient record and include procedures performed at the bedside.
- IV. If the patient requires transport to another facility, during the initial resuscitation period, a dictated note will be sent with the patient for transfer. In addition, the resident or attending will give a verbal report to the receiving physician.
- V. If the patient requires transport during any other phase of care, the discharge summary will be dictated and sent with the patient.

Origination date: 12/31/1998

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Approved by: MED DIR, TRAUMA, PHYSICIAN, SURGEON

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