

Section 9	Clinical Policies	05/15/96 - Originated
Subject 9.2	Patient Records	05/05/14 - Reviewed w/ changes
		08/15/00 - Reviewed w/o changes
Policy 9.2.15	Medical Record Documentation	05/28/14 - Effective
		Health Information Management - Author

Medical Record Documentation

Policy

It is the policy of UTMB to initiate and maintain a complete and accurate medical record for every individual assessed, cared for, treated, or served. Documentation in the medical record shall be sufficient to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among health care providers. Medical record documentation is to be timely, meaningful, authenticated, and legible. All relevant documents and entries should be entered into the medical record at the time the service is rendered. The electronic medical record (EMR) must be used for documentation in all areas where its implementation has been completed.

Every individual documenting in the medical record is responsible for the entire content of his/her documentation, whether the content is original, copied, pasted, imported or reused. Those who document are responsible for the accuracy, medical necessity, and documentation requirements of each of their notes.

In addition, they are responsible for the proper maintenance of their In Basket by reviewing it regularly to prevent delinquencies in the medical record. Faculty members should ensure that resident notes are accurate and consistent with this policy at the time of co-signing any note.

More specific documentation requirements can be found in the [Medical Staff Bylaws, Medical Staff Rules and Regulations](#), and the booklet, "The Medical Record and Health Information Management Services" published by the Department of Health Information Management (HIM).

Guidelines

Legibility

1. All entries must be legible, including handwritten/electronic signatures.
2. Black ink is recommended for hardcopy medical record entries.

Patient Identification

1. Every page in the medical record or electronic medical record screen must be identifiable by patient name and complete medical record number (including the alpha suffix). It is preferred that this information be available on both sides of a document.
2. If the Department of Health Information Management (HIM) receives documents with incomplete, illegible and/or missing patient identification, an attempt will be made to properly identify the patient. Documents successfully identified will be

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incorporated into the medical record.

Documents on patients who cannot be identified will be returned to the originating areas. If the originating area cannot be identified, HIM will forward the documents to the appropriate clinic/nursing administrator for resolution. Upon receipt in the clinic or administrative area, one of the following will occur:

- a. The patient will be identified, demographic information added and the document returned to HIM for filing; or
- b. If the patient cannot be identified, the document will be [properly destroyed](#) in accordance with IHOP 6.1.10, Physical Protection Safeguards for Protected health Information.

Authentication

1. Signatures must include first name or initial, last name, and employment/status (e.g., JMS) or licensure status (e.g., M.D.). *Initials alone are not acceptable.*
2. For authenticating paper medical record documentation, handwritten signatures may be accompanied either by the author legibly writing his/her name in block print or by the use of a name stamp accompanied by a signature. *The use of a signature stamp is not acceptable.* In addition, the physician number or provider identification number should be documented.
3. Faxed signatures are acceptable.
4. For authenticating electronic medical record documentation, electronic signatures may be used.
 - a. Authentication is the information security process that verifies a user's identity and authorizes the individual to access an information system.
 - b. Authentication assigns responsibility to the user for entries he or she creates, modifies, or views.
 - c. Users shall not share their UTMB account(s), passwords, Personal Identification Numbers (PIN), security tokens (e.g., Smartcard), or similar information or devices used
 - d. The individual identified by the electronic signature or method of electronic authentication is the only individual who may use it, as it denotes authorship of medical record documents in electronic medical records.

Content

1. Abbreviations should be used cautiously to avoid misinterpretation. *Medical Abbreviations* by Neil M. Davis may

be used as a guide. Abbreviations listed on the [Prohibited Abbreviations List](#) may not be used in the medical record.

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2. Every blank space or field should be filled in (e.g., both negative and positive test results should be recorded, and “not applicable” indicated when appropriate).
3. Only relevant, objective information should be documented in the medical record. Extraneous information and subjective characterizations of events should not be documented
4. New documentation should not be added to a page printed from an EMR. If new documentation is needed, a new note/report should be added in the EMR or paper legal medical record.
5. Documentation in the EMR should be entered according to [UTMB’s style guide](#). The adherence to this [style guide](#) provides uniformity in style and formatting of the medical record.

Time Documentation

1. All entries must be timed (military format) and dated (month day and year).
2. Medical record entries must be completed in a timely manner. Entries should be made when the treatment described is given or the observations to be documented are made, or as soon as possible thereafter.
3. An entry should never be made in advance.
4. If an entry is made retrospectively on a paper document, it must reflect the date and time the entry is actually made. Note the reason for the late entry, and sign with a full signature.
5. Authors should review and sign their notes promptly

Document Corrections

When it is discovered that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service, these entries must:

1. Be clearly and permanently identified as an amendment, correction or delayed entry, and
2. Be completed as soon as possible after the need for amendment, correction or delayed entry is identified, and
3. Clearly indicate the date, time, and author, and
4. Not delete but instead clearly identify all original content, and Identify or refer to the date and incident (original content) for which the delayed entry, amendment or correction is written, and
5. Identify any sources of information to support the delayed entry, amendment or correction.

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There is no time limit to write a late entry, amendment or correction; however, the more time that passes, the less reliable the entry becomes.

Paper Medical Records

When correcting a paper medical record, use a single line strike through so that the original content is still readable. The author of the alteration must sign, date and time the revision. Similarly, amendments or delayed entries must be clearly signed, dated and timed upon entry into the record.

EMR information cannot be altered after it is electronically signed or the document closed. In order to make a correction, amendment or delayed entry, follow the appropriate [manual chart correction processes](#). If someone other than the author identifies a documentation error, the Information Services Help Desk should be notified.

For guidelines on how to correct, addend, remove or revoke a document (e.g. consents, authorizations, DNRs advance directives, operative reports) that has been scanned into the EMR, refer to IHOP 9.2.16 Scanning PHI to Epic.

Loose Medical Document Handling

Hardcopy medical record documents approved for inclusion in the official medical record are to scanned into the EMR via MyUTMB, by HIM or responsible clinic or ancillary staff, thus making this information available to any health care provider.

Once an official medical record document is added to a paper medical record it should not be removed except by a trained HIM employee. Documents will only be removed if one of the following has occurred:

1. The document was filed in the wrong patient's record;
2. The document is a duplicate of an original that is already contained in the record;
3. The document is not an approved medical record document (e.g., financial data);
4. HIM approves the removal of the document.

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References

IHOP 6.2.10 Physical Protections/Safeguards for Protected Health Information

[IHOP 6.1.12 Disposal of PHI](#)

IHOP 9.2.16 Scanning Protected Health Information to Epic