

Institutional Handbook of Operating Procedures Policy 09.02.15	
Section: Clinical Policies	Responsible Vice President: Executive Vice President & CEO UTMB Health System
Subject: Patient Records	Responsible Entity: Health Information Management

## I. Title

*Medical Record Documentation*

## II. 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.

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 resource, “The Medical Record and Health Information Management Services Handbook” published by the Department of Health Information Management (HIM).

## III. Guidelines

If applicable, this section provides the UTMB community with a sequential, step-by-step guide of all actions required to comply with the policy. The procedures should be clear and concise.

### 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 incorporated into the medical record.

Documents on patients which cannot be identified will be kept for 90 days. If after this time they still can't be identified, they will be disposed of properly 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 Do Not Use List can be found on the Medical Abbreviations menu tab.
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.

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.

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 be 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.

## IV. Relevant Federal and State Statutes

[Texas Administrative Code Title 22, Part 9, Chapter 165](#) (Medical Records)

## V. Related UTMB Policies and Procedures

[IHOP - 06.02.10 - Physical Protections/Safeguards for Protected Health Information](#)

[IHOP - 06.03.01 - Use of Cloned Documentation in the Electronic Medical Record](#)

[IHOP - 09.02.16 - Scanning Protected Health Information to Epic](#)

## VI. Dates Approved or Amended

<i>Originated: 05/15/1996</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
05/28/2014	08/15/2000
11/19/2019	
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**VII. Contact Information**

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