

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).

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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