

Medical Record Documentation

Policy

It is the policy of UTM&B 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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Sample Medical Documentation

Sabine Zange



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101 Sample Write-Ups for Documenting Employee Performance Problems Paul Falcone, 2010-03-24 Whether you're addressing an initial infraction or handling termination worthy transgressions you need to be 100 percent confident that every employee encounter is clear, fair and most importantly legal. Thankfully HR expert Paul Falcone has provided this wide-ranging resource that explains in detail the disciplinary process and provides ready-to-use documents that eliminate stress and second-guessing about what to do and say. Revised to reflect the latest developments in employment law, the third edition of 101 Sample Write-Ups for Documenting Employee Performance Problems includes expertly crafted, easily customizable write-ups that address sexual harassment, absenteeism, insubordination, drug or alcohol abuse, substandard work, email and phone misuse, teamwork issues, managerial misconduct, confidentiality breaches, social media abuse and more. With each sample document also including a performance improvement plan, outcomes and consequences and a section of employee rebuttal, it's easy to see why over 100,000 copies have already been sold, making life for managers and HR personnel significantly easier when it comes to addressing employee performance issues. The Compliance Guide to the JCAHO's Medication Management Standards Michael R. Hoving, 2005 Spanish and the Medical Interview: Clinical Cases and Exam Review - E-Book Pilar Ortega, Marco Alemán, 2021-07-10 Offering a practical, case-based approach, Spanish and the Medical Interview: Clinical Cases and Exam Review is a unique, immersive study and review resource for medical Spanish. It provides extensive training and review in two formats: the print book contains numerous cases spanning a wide variety of clinical settings, formatted as a patient would present for medical attention, while the audio cases provide multiple opportunities to hone your listening comprehension skills. Together, these learning components test your knowledge and skills in caring for Spanish-speaking patients and prepare you for case-based examinations that test clinical skills in Spanish. This, first of its kind, title is ideal as a stand-alone resource or as a companion to Dr. Ortega's Spanish and the Medical Interview: A Textbook for Clinically Relevant Medical Spanish. Helps you improve your interviewing skills, your understanding of patient responses and your ability to explain a diagnosis and plan of care to Spanish-speaking patients so you can provide a higher quality of patient care and safety in your practice. Covers multiple presentations of cases in main organ system areas including musculoskeletal, cardiovascular, pulmonary, gastrointestinal, endocrine, genitourinary, neurologic, psychiatric, eye, ear, nose, throat and pediatric in multiple patient care settings such as urgent care, emergency department, outpatient clinic and inpatient wards. Focuses on topics that are particularly common in Hispanic/Latino patients and includes cultural health issues that may impact the patient's understanding of medical information, belief system, decision-making preferences or access to care, all of which have a significant impact on your medical decision-making and interviewing styles and effectiveness. Leads you through key information for each case, prompting you to use your medical Spanish clinical skills in a series of prompts and questions as the case unfolds. Assessment questions follow each case to test your comprehension. Provides more than two dozen audio

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Catalog of Public Use Data Tapes from the National Center for Health Statistics National Center for Health Statistics (U.S.), 1988

Clinical Nursing Skills Christy Bowen, 2024-09-16 Clinical Nursing Skills is designed to equip nursing students with the practical knowledge and hands on skills necessary to provide comprehensive patient care The material emphasizes the application of clinical judgment in a variety of settings ensuring that students are prepared to deliver high quality care across different patient populations and clinical scenarios The content utilizes concepts promoting the development of clinical judgment by building upon the systematic model developed by the National Council of State Boards of Nursing NCSBN Clinical Nursing Skills provides detailed instructions on basic procedures such as hygiene mobility vital signs assessment medication administration and wound care It also guides students through more complex skills including intravenous therapy catheterization tracheostomy care and emergency interventions By integrating the Clinical Judgment Measurement Model the material helps students recognize analyze prioritize create act and evaluate outcomes in various clinical situations fostering critical thinking and clinical decision making By studying Clinical Nursing Skills students will gain the confidence and competence needed to perform essential nursing tasks make informed clinical decisions and provide compassionate patient centered care which will prepare students for success in their clinical rotations and future professional practice This is an adaptation of Clinical Nursing Skills by OpenStax You can access the textbook as pdf for free at openstax.org Minor editorial changes were made to ensure a better ebook reading experience Textbook content produced by OpenStax is licensed under a Creative Commons Attribution 4.0 International License

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