

	Cooper Green Mercy Health Services		POLICIES & PROCEDURES: ADMINISTRATIVE	
	APPROVED: 		ISSUED: 1/16	PAGE: Page 1 of 5
SUBJECT: Medical Record Usage			REVISED:	REVIEWED:

I. BACKGROUND

The patient record is legal documentation of every individual who has been treated or received medical or health care services at Cooper Green Mercy Health Services. It contains the patient name, age, identifying information, reason for the visit or service, the diagnosis including all supportive information for that diagnosis, and all data that is obtained during the visit. It is a continuous document in that all clinical encounters with an individual are maintained in a single distinct uniquely identifiable medical record. Information that is stored in the medical record must follow all state and federal regulations.

The medical record, whether written or electronic, is health information that is protected by HIPAA's privacy regulations. As a result, any unauthorized disclosure of the medical record is protected by federal regulation and punishable by fine and by imprisonment.

The medical record policies clarify what information is required to be entered into the medical record, to whom permission is granted to enter information into the medical record, how that information must be presented, how errors are corrected, retention requirements, and charges for duplicating the record.

The current medical record is electronic in nature, and, as of this policy date, the official medical record of Cooper Green Mercy Health Services exists in a software program maintained and managed by Medsphere Systems Corporation, through their OpenVista[®] portfolio, which includes the CareVue electronic health record (EHR.) CareVue is the official medical record for Cooper Green Mercy Health Services, dating back to its "go live" implementation, May 1, 2012. Associated through sub-contract by Medsphere is the financial and revenue cycle component of the EHR, Stockell Healthcare Systems and its product - InSightsCS[®]. InSightsCS[®] is not considered a component of the EHR. However, both components are protected by HIPAA's privacy regulations.

Prior to May 1, 2012, the hard copy of the medical record, in conjunction with selected portions of the electronic health record created in the Meditech, a product of Medical Information Technology, Inc., served as the official medical record. The record is maintained according to law by the Custodian of Records in Health Information Management.

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II. PURPOSE

The purpose of this policy is to provide guidelines for the physicians and staff of Cooper Green Mercy Health Services, when documenting in the medical record.

III. POLICY

It is the policy at Cooper Green Mercy Health Services to maintain a quality medical record which is carefully documented, complete, accurate, legible, relevant, timely, secure and informative.

IV. PROCEDURE

A. Basic Principles for Documentation in the Medical Record: The standard format for a medical record at Cooper Green Mercy Health Services will be in an electronic form (EHR) as established by the Director of the facility, in consultation with the medical and executive staff. It should be noted that many of the elements required in the medical record are automatically promulgated in an EHR.

- 1) Verify documentation is in the correct medical record by checking that the patient's name and date of birth are correct.
- 2) All entries should be legible and written in ink.
- 3) All entries should be dated with the month, day and year, i.e. 05/1/2012.
- 4) Complete all appropriate sections of the patient medical record.
- 5) Document if a patient refuses treatment, advice or hospitalization; or if they don't want to know the risks/side effects of a treatment plan.
- 6) Avoid negative comments or criticism regarding a patient.
- 7) Any entries must be signed electronically or with first initial, last name and title, or initials are appropriate if a log has been established to record all staff initials for identification.
- 8) The person who fills out the history portion of the visit must sign in the appropriate space.
- 9) All diagnostic tests must be reviewed, signed electronically (or initialed and dated by a Cooper Green Mercy Health Services physician) before being placed in a patient's medical record.
- 10) The patient's name and birth date must appear on every page of the patient's medical record.

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- 11) Any signed document that is released from the clinic must be copied and retained in the patient's permanent medical record, i.e. prescriptions, work notes, PCP follow up letter, et al.
- B. Completeness: Each record shall contain the specific information needed to justify the diagnosis and course of treatment; therefore, a medical record shall be considered complete when it contains the following:
- 1) Documentation appropriate to the particular episode of care
 - 2) Proper authentication of all entries
 - 3) Complete and consistent diagnosis
- C. Timeliness: As far as possible, medical record documentation shall be completed in an on-going manner throughout the encounter. When data entries are not completed by the time of discharge or encounter, the following time frames and definitions shall apply
- 1) Incomplete – Lacking required data elements or authentication at the time of discharge or occurrence.
 - 2) Delinquent – Incomplete record that is 30 days post discharge or occurrence.
- D. Documentation Features: Entries in the medical record shall be made to reflect each patient event, episode or encounter of care. These entries shall be characterized by generally accepted documentation features, including the following:
- 1) Documented as close to the time of the actual event, as feasible.
 - 2) Late entries and addenda so noted and the reason for lateness provided
 - 3) Identifiable and clearly noted date and time
 - 4) Legible entries
 - 5) No pre-charting in anticipation of an event
- E. Accuracy: The medical record is a confidential document and/or combination of documents created in the normal course of patient care from initial assessment to conclusion of treatment. This document is created in the sequence of events as they occur. Complete and accurate medical record documentation shall be developed and maintained for the primary purpose of fostering continuity of

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patient care by maintaining a means of communication among health care practitioners treating a patient presently or in the future.

F. To Correct an Error:

- 1) Signed entries in an EHR can only be deleted by authorized personnel in the Health Information Management Department. However, changes can be completed as an addendum to the incorrect document. The addendum must then be signed electronically in the document for completeness, as appropriate.
- 2) For paper documents that have been scanned into the EHR, an error can be addressed by creating and signing an amendment to the note that includes the scanned document.
- 3) Should changes to a paper entry be required, the changes should be as follows.
 - (a) Draw a single line through the entry being corrected.
 - (b) Write 'error' and first initial, last name, and title above the entry or in the margins of the line that is being corrected.
 - (c) Do not use correction fluid/tape in the event record.
 - (d) Do not attempt to erase an error.
 - (e) Do not draw arrows to add information. It is best to cross out and rewrite the entry correctly. If information must be added at a later time, it should be added on a progress note (preferably in the EHR indicating that it is an addition or an addendum to a previous entry. This entry must be dated and signed with first initial, last name and title.

G. Provider Identification Log:

- 1) A log of all employees with access to the EHR will be maintained within the EHR as entered by the Information Technology Department on completion and verification of the appropriate documentation. Information Technology will be the guardian and issuer of screen names and access passwords.
- 2) The log will be initiated by Information Technology and collaboratively maintained with the Custodian of Records electronically.
- 3) An electronic signature of the providers private choosing will be used for completing the particular component of the record. The electronic signature code is a confidential code, not to be shared with anyone. Sharing the signature code can result in progressive disciplinary action, up to and

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including employee termination and/or immediate cancelation of contractual relationships.

- 4) All employees, physicians, interns and externs, et al, who document in a patient's medical record will complete the appropriate documentation to maintain this log at the time of hire with their first initial, last name and title along with their initials in the appropriate blanks. Until this is done, initials may NOT be used in a patient's medical record, should a paper record be required.
- H. Confidentiality must be maintained at all times. All staff that work for Cooper Green Mercy Health Services, must sign a confidentiality statement upon hire which will be kept in their personnel file.
- I. Active and Inactive Records.
- 1) Paper Records: Primary storage of paper medical records will be at Cooper Green Mercy Health Services under the direction of the Custodian of Records. Inactive records may be copied to an electronic or microfiche format and stored in an accessible location, either on or offsite, at the recommendation of the Custodian of Records, based on compliance with state and federal laws and regulations.
 - 2) Electronic Records
 - (a) Primary Storage: Primary storage of the electronic records will be on a server located in a Jefferson County owned facility (for example, at Cooper Green or at the Courthouse.)
 - (b) Back-up Storage: Electronic record back up will be maintained in a secured, approved, HIPAA compliant off site electronic database according to Jefferson County Commission policy
 - (c) Inactive Records: As records become inactive due to lack of contact with the patient, the records may be purged and stored in an appropriate place or destroyed. When records are purged, a record will be maintained allowing easy access when retrieval is required. Purged records are maintained according to laws outlined by the State of Alabama. Record destruction will be in accordance with applicable state and federal laws and regulations. A reference copy of the Alabama rules and regulations regarding record retention published by the Alabama Association of Health Information Management is maintained in the Health Information Management Department at Cooper Green Mercy Health Services.