HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: VII-100 MANAGEMENT OF HEALTH RECORDS	**POLICY #**: 1251 **VERSION:** 2
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DATE APPROVED: 09/29/2017	

PURPOSE: The Ambulatory Surgical Center (ASC) and Health Information Management (HIM) Department maintains a medical record system that supports the diagnosis, treatment and care of ASC patients using current standards for all medical record functions using a unique patient identifier.

POLICY: All health records are assembled, coded, completed and maintained by a HIM/ASC employee in accordance with standards established by HDRHC/ASC MOU, Los Angeles County Department of Health Services, State and Federal regulatory and accrediting agencies. The patient's paper record is considered the official record, until it is completed/closed and scanned into EDM. Once the record has been closed, the paper record is sent off-site storage (OFS) and the scanned record becomes the official record.

PROCEDURE:

A. ASC Supervising Nurse, Anesthesia, Surgery and Quality/Risk Management Director review ASC health records and preform a qualitative analysis of each record to ensure adequate patient care and safety as well as compliance with documentation expectations. ASC HIM staff performs quantitative analysis of each record to ensure compliance with licensure standards and refer deficient records to the responsible physician or nurse for completion. No record can be considered complete until it has met established policies.

B. ASC medical records shall be stored or scanned to facilitate immediate retrieval of health information.

MEDICAL RECORD LOCATION:

ASC medical records will remain open, for no more than 45 days following the surgical or invasive procedure, until compliance with standards is met. ASC closed records will be scanned into the EHR within 48-hours of receipt.

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Most paper ASC charts have been scanned into the EDM system and are available electronically or may be requested through the High Desert Regional Health Center HIM Department to be retrieved from off-site storage within 48-hours and scanned into the current electronic health record.

MEDICAL RECORD RETENTION:

A. ASC medical records are preserved for a minimum of ten (10) years without activity following the last encounter.

B. Medical records of minors are preserved until the child's 25th birthday **and** with no activity for ten (10) years following the last encounter.

C. Should the ASC cease operations, facility must notify, within 48 hours, the Department of Health of its plan for the safe preservation of medical records. Should the facility change ownership, written documentation must be provided by both the old and new licensee, outlining the arrangements made for transfer of medical record custody, safe preservation of the records, and access to the information by both the new and old licensees and other authorized individuals. (Title 22, section 70751)

CONFIDENTIALITY

A. HDRHC Health Information Management, per ASC MOU, is the custodian of records and shall respond to inquiries about ASC patient record request.

B. No record shall be released except in accordance with HDHS ASC P&P (…), California State laws, HIPAA regulations and all other laws that may apply. All releases of ASC medical information requires the patient or the patients' legal representatives to provide written authorization except when permitted by HIPAA regulations.

MEDICAL RECORD COMPLETION AND ORGANIZATION:

A. HISTORY AND PHYSICAL

1. A dictated history of physical or the abbreviated history and physical form must be completed within 30 days of the planned procedure and filed in the medical record prior to the scheduled procedure.

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2. The history and physical shall contain the following elements whether dictated or written:

    - Reason for Procedure
    - History of Present Illness
    - Past Medical History/Review of Systems
    - Social History
    - Current Medications
    - Allergies
    - Physical Examination
    - Assessment/preoperative diagnosis
    - Planned procedure
    - Date and time of dictation
    - Physician authentication

3. If the History and Physical was completed prior to the day of surgery, on the day of the scheduled procedure, the patient assessment will be updated for any changes in condition and documented on the History and Physical form prior to surgery, and placed in the medical record.

4. All spaces on the History and Physical form must be completed and not crossed out or have a Ø symbol in the space.

5. If the History and Physical is not present or is found not to be complete prior to surgery, and the operating physician will not complete it, the procedure will be cancelled.

B. OPERATIVE REPORT:

1. A handwritten operative progress record must be completed, dates and timed by the operating Surgeon immediately following the procedure. All spaces on the Operative Progress Records must be completed.

2. The dictated operative report shall contain the following elements:

    - Name of the primary surgeon
    - Name of the assistant surgeon and other assistants

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- Anesthesiologist and Anesthesia type
- Preoperative diagnosis
- Postoperative diagnosis
- Procedure used
- Specimens removed
- Estimated blood loss
- Blood/fluid administered
- Complications, if any
- Date and time of dictation
- Physician authentication

3. Prior to the patient's discharge, a dictated operative report must be completed.

4. The dictated operative report must be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

C. DOCUMENT ORDER

The open ASC chart order is created and maintained by Nursing. Once received in HIM the loose documents are scanned into the EHR and sent to off-site storage.