Health Services
LOS ANGELES COUNTY

POLICIES AND PROCEDURES

SUBJECT: LEGAL MEDICAL RECORD

POLICY NO: 390.101

PURPOSE:

To establish guidelines for the content, maintenance, and confidentiality of patient medical records that meet the requirements set forth in federal and State laws and regulations, and to define the portion of an individual's healthcare information, paper or electronic, that comprises the legal medical record. Patient medical information is contained within multiple electronic record systems in combination with financial and other types of data. This policy defines requirements for those components of information that comprise a patient's complete and Legal Medical Record.

POLICY:

DHS will ensure a single medical record is initiated for each individual DHS patient for continuity of care and legal purposes.

DHS adheres to all State and federal laws as well as other applicable regulatory requirements in recognition that medical records are confidential and shall not be released or disclosed to any unauthorized persons.

DEFINITIONS:

"Legal Medical Record ("LMR)" means the collection of information, in paper or electronic format, concerning a patient that is generated at or for the Department of Health Services (DHS) as its business record and is the record that will be disclosed upon request. It does not affect the discoverability of other information held by the organization.

The LMR is the documentation of healthcare services provided to an individual during any aspect of healthcare delivery in any type of DHS facility. The LMR contains individually identifiable data, stored on any medium, and collected and directly used in documenting healthcare or health status.

The LMR must meet accepted standards as defined by applicable Centers for Medicare and Medicaid Services Conditions of Participation, federal regulations, state laws, and standards of accrediting agencies such as JCAHO, as well as the policies of Los Angeles County Department of Health Services.

APPROVED BY:
REVIEW DATES:

EFFECTIVE DATE: May 1, 2007
SUPERSEDES:

"Designated Record Set" means a group of records maintained by or for DHS that includes medical, billing enrollment, payment, claims adjudication and other records used to make decisions about an individual.

PROCEDURES:

I. Maintenance of Medical Record

A medical record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient of a DHS facility.

Currently, the medical record is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the LMR may physically exist in separate and multiple paper-based locations or electronic formats.

The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, and fetal monitor strips when a written or dictated summary or interpretation of findings has not been prepared.

The current electronic components of the LMR consist of patient information from multiple Electronic Health Record source systems, including but not limited to the Hospital Information System (HIS) laboratory systems, radiology system and intensive care system.

The paper chart shall contain original reports. Clinic charts may only contain copies of medical records. Original documentation must be sent to the designated Medical Records department or area.

II. Confidentiality

The medical record is confidential and is protected from unauthorized disclosure by law. The circumstances under which DHS may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices. Content

Medical record content shall meet all State and federal legal, regulatory and accreditation requirements, including but not limited to, Title 22 California Code of Regulations (CCR), sections 70749, 70527 and 71549, and the Medicare Conditions of Participation 42 Code of Federal Regulations (CFR) section 482.24. This policy contains a listing of required medical record documentation content, and current electronic or paper format status.

Additionally, all hospital records and hospital based clinic records must comply with the applicable hospital's Medical Staff's By-Laws, Rules and Regulations requirements for content and timely completion.

All documentation and entries in the medical record, both paper and electronic, must be identified with the patient's full name and a unique DHS facility's medical record number. All double-sided or multi-page forms must also have both identifiers on each page, as a subsequent page becomes a single document once photocopied, faxed or imaged.

All entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in advance of the service. Pre-dating or backdating an entry is not permitted.

III. Who May Document in the Multidisciplinary Notes

The following DHS employees and/or employees of contracted clinical and social services may document entries in the Multidisciplinary Notes section of the medical record:

- Clinical Social Workers
- Dentists
- Dietitians/Diet Technicians
- Emergency Trauma Technicians
- Fellows
- Home Health Coordinators
- Clinical Care Partners
- Hyperbaric Technicians/Observers
- Interns
- Interpreters

- Licensed Vocational Nurses
- Medical Assistants
- Medical Ethicist
- Nurse Practitioners
- Occupational Therapists
- Osteopathic Students
- Pastoral Care Providers
- Pharmacists
- Physical Therapists
- Physician Assistants
- Physicians including MD's and DO's
- Psychologists
- Registered Nurses
- Mental Health Practitioners
- Licensed Psychiatric Technicians
- Midwives
- Residents
- Respiratory Therapists
- Speech Pathologists
- Students, e.g., MD, RN, Occupational Therapy, etc. ***(Notations in the record must be cosigned by supervising clinician)***

IV. Completion, Timeliness and Authentication of Medical Records

A. All inpatient medical records must be completed within 14 days from the date of discharge. (California Code of Regulations, Title 22, section 70751) Additional requirements may also be included in the applicable DHS hospital Medical Staff's By-Laws, Rules and Regulations.

B. All operative and procedure reports must be completed immediately after surgery.

C. All medical record entries are to be dated, timed and authenticated. The authentication must be made by the individual who is the originator of the document or entry.

D. Certain electronic methods of authenticating the medical record, such as passwords, access codes, or key cards may be allowed provided certain requirements are met.

The methodology for authenticating the document electronically must comply with regulatory, accreditation and hospital policies. (See Section XIV below: Authentication of Entries)

The entries may be authenticated by a computer key, in lieu of a medical staff member's signature, only when that medical staff member has placed a signed statement with the facility to the effect that the member is the only person who: 1) has possession of the key (or sequence of keys); and 2) will use the key (or sequence of keys). Fax signatures are acceptable.

V. Medical Record Forms

Every new form and every revised form must be approved prior to use in the medical record through the facility's medical record forms process. Forms may not contain any shaded areas. Acceptable alternatives to shading include bold text, italicized text, and underlining.

All new medical record forms and electronic data systems must also be reviewed and approved through the forms approval process.

VI. Routine Requests for Purposes of Treatment, Payment and Healthcare Operations.

Routine requests for medical records will be processed by the Health Information Management Services staff. Charts physically removed from the medical record storage areas will be logged in the computerized tracking system with a record of the staff name, department, date record provided, and contact phone number.

Only authorized DHS facility workforce members may access medical records in accordance with Privacy Policies and Procedures. Access to medical records is based on the amount of information needed to complete job responsibilities.

A. Access to Medical Records for Treatment Purposes

Healthcare providers who are directly involved in the care of the patient may access full medical record.

B. Payment Purposes

Authorized and designated DHS workforce members may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

1. Coding,
2. Billing including claims preparation, claims adjudication and substantiation of services,
3. Utilization Review, and
4. Third Party Payer Reviews (including Quality Improvement Organization reviews)

C. Healthcare Operations

Patient medical records may be accessed for routine healthcare operations purposes, including but not limited to:

1. Peer Review Committee activities,
2. Quality Management reviews including outcome and safety reviews,
3. Documentation reviews,
4. Teaching,
5. Compliance reviews including auditing, fraud and abuse detection and prevention, and
6. Risk management and University legal counsel reviews.

D. Requests for Electronic Components of the Medical Record

Personnel who access the electronic medical record are required to have a unique User ID and password. Access to information is restricted by job title, individual need to know or need to complete job duties, as approved by designated management personnel.

VII. Requests for Non-Treatment, Payment or Healthcare Operations ("Non-TPO") Purposes (Accountable Disclosures)

All non-routine requests, and requests for Non-TPO purposes which must be included in the accounting of disclosures provided to the patient, will be forwarded to the Health Information Management Department Supervisor/Manager or Privacy Coordinator for review and coordination. These include, but are not limited to, the following:

1. Research;
2. Subpoena;
3 Court orders;
4. Workers' Compensation;
5. Mandatory reporting;
6. Accreditation surveys;
7. Law enforcement; and
8. Governmental agencies.

VIII. Ownership and Maintenance of Medical Records

All medical records of DHS facilities, regardless of whether they are created at, or received by DHS facilities, patient lists and billing information, are the property of DHS. The information contained within the medical record belongs to the patient.

Original records may not be removed from the DHS facility and/or offices except by court order, subpoena, or as otherwise required by law or hospital policy.

If an employed physician or provider leaves or is terminated by the DHS for any reason, he or she may not remove any original medical records, patient lists, and/or billing information from the facility and/or office. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to the DHS facility.

Chronology is essential and close attention shall be given to assure that documents are filed properly, and that information is entered in the correct medical record for the correct patient, including appropriate scanning and indexing of imaged documents.

IX. Right to Request Amendment to Medical Record

Each patient has a right to request an amendment to the information contained within his or her medical record or request an addendum be added. The individual patient must make the request for amendment in writing and provide a reason to support the requested amendment. The patient may also request an addendum of up to 250 words be attached to the medical record. The request for addendum and/or amendment is to be forwarded to the Health Information Management Department.

X. Retention and Destruction of Medical Records

All medical records are retained for at least as long as required by State and federal law and regulations, and DHS policies and procedures related to record retention.

Original hard copies of patient records may only be destroyed as per DHS policy. The printout of the computerized version shall be considered as legally valid as the original. The electronic version of the record must be maintained per the legal retention requirements as specified in DHS record retention policies.

No original records will be destroyed until verification of the completeness and clarity of the scanned document.

XI. Medical Records Management

The electronic elements of the medical record are available at all times via the hospital's computer systems.

The Health Information Management Department utilizes a unit numbering system for the paper-based patient medical records. Outpatient records in some locations are maintained in a separate record folder, however all records are retrievable by the unit medical record number and encounter location information in the DHS hospital information system.

The components and documents comprising the electronic medical record are linked together utilizing the uniquely assigned patient medical record number.

Requests for paper records will be processed by retrieval from the Health Information Management File Room, and responded to in the following sequence:

1. Emergency care requests;
2. Other unscheduled patient care requests;
3. Patient care requests in time of appointing order;
4. Requests related to payment activities;
5. Healthcare operation requests; and
6. Research requests.

XII. Permanency and Legibility of Record

All medical records, regardless of form or format, must be permanently maintained in their entirety, and no document or entry may be deleted from the record.

Handwritten entries should be made with permanent black ink. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. Highlighters should never be used.

All entries in the medical record must be legible to someone other than the author.

XIII. Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated, and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient", etc. The contents of medical records must not otherwise be edited, altered, or removed.

A. Documents created in a paper format

Labels may not be placed over the entries for correction of information.

If information in a paper record must be corrected or revised, a line is drawn through the incorrect entry and the correction is dated, reason for revision noted, and signed by the person making the revision.

If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above, and rescanning the document. The original document is then voided in the electronic system.

`B. Documents that are created electronically must be corrected by one of the following mechanisms:

Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.

Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong date, wrong attending assigned).

Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, location, duplicate documents, incomplete documents, or other errors. The amended version must be reviewed and signed by the provider.

Sometimes it may be necessary to re-create a document or move a document that posted incorrectly or was indexed to the incorrect patient record.

The HIMS Department will be responsible to ensure that the documentation is corrected and appears under the applicable patient medical record number. **The incorrect document will remain in the incorrect patient record, with the contents of the document electronically "blanked out." However, the original document will remain permanently in the system as a prior version of the document.** The document will be re-created in the correct patient's record with a notation that the record was initially incorrectly created with an incorrect patient medical record number. For other documents, originating in some vendor systems, the document will remain in the incorrect patient record with an addendum, or a cancellation notation. The document will be re-created in the correct patient's record as well.

C. <u>When a patient entry was missed or not written in a timely manner, the author must meet the following requirements:</u>

1. Identify the new entry as a "late entry."
2. Enter the correct date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time.
3. Identify or refer to the date and circumstance for which the late entry or addendum is written.

When making a late entry, document as soon as possible. There is no time limit for writing a late entry, however the more time has elapsed, the less reliable the entry becomes.

D. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry

1. Document the current date and time.
2. Write "addendum" and state the reason for the addendum referring back to the original entry.
3. When writing an addendum, complete it as soon as possible after the original note.

E. Errors in Scanning Documents

If a document is scanned with wrong encounter data or the wrong patient information, the following must be done:

1. Reprint the scanned document
2. Rescan the document to the correct date or patient, and void the incorrectly scanned document.

F. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation. Mechanisms may vary from one system to another.

In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as for paper.

The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.

When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

XIV. AUTHENTICATION OF ENTRIES

Authentication is the process used to verify that an entry is complete, accurate and final.

Every entry in the medical record must be authenticated by the author. At a minimum, the authentication should include the first name, last name, and professional title/credential of the author. It is recommended that handwritten signatures include the pager number and/or printed name and title.

Electronic signatures must meet standards for:

- Data integrity to protect data from accidental or unauthorized change (for example "locking" of the entry so that once signed no further changes can be made to the entry);
- Authentication to validate the correctness of the information and confirm the identity of the signer (for example requiring signer to authenticate with password or other mechanism);
- Non-repudiation to prevent the signer from denying that he or she signed the document (e.g., public/private key architecture);
- At a minimum, the electronic signature must include the full name and credentials of the author, and include date and time (including time zone) signed.

Electronic signatures must be affixed only by that individual whose name is being affixed to the document and no one else.

Countersignatures or dual signatures must meet the same requirements and are used as required by State law and Medical Staff's By-Laws Rules and Regulations.

Initials may be used to authenticate entries on flowsheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.

Rubber stamp signatures shall not be used for authentication of entries in the medical record. Documents with multiple sections or completed by multiple individuals should include a signature area on the document for staff to sign and date.

Staff who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.

Electronic signature keys must not be shared by the individual with any other individual.

XV. DESIGNATION OF SECONDARY PATIENT INFORMATION

The following three categories of data contain patient information and are provided the same level of confidentiality as the LMR, but are not considered part of the legal medical record.

Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. They are often maintained at the department level, in a separate location or database and are retrievable only upon request.

Examples:

- Preliminary versions of transcribed reports
- Photographs for identification purposes only
- Audio of dictation or patient phone call
- Communication tools (i.e., Kardex, patient lists, work lists, clinician in-baskets and messaging, sign out reports, FYI, etc.)
- Protocols/clinical pathways, best practice alerts, and other knowledge sources
- Patient's personal health record provided by the patient to their care provider

Alerts, reminders, pop-ups and similar tools are used as aides in the clinical decision making process. The tools themselves are not considered part of the legal medical record. However, the associated documentation of subsequent actions taken by the provider, including the condition acted upon and the associated note detailing the examination, are considered components of the legal medical record. Similarly, any annotations, notes, and results created by the provider as a result of the alert, reminder or pop-up are also considered part of the legal medical record.

Some source data are not maintained once the data has been converted to text. Certain communication tools are part of workflow and are not maintained after patient's discharge.

Administrative Data is patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include but are not limited to:

- Authorization forms for release of information
- Correspondence concerning request for records

- Birth and death certificates
- Event history/audit trails
- Patient-identifiable abstracts in coding system
- Patient-identifiable data reviewed for quality assurance or utilization management
- Administrative reports
- Derived Data consists of information aggregated or summarized from patient records so that there are not means to identify patients. Examples:
  - Accreditation reports
  - Best practice guidelines created from aggregate patient data
  - ORYX reports, public health records and statistical reports

XVI. Downtime Procedure

In the event the EMR system (e.g., Affinity, health notes, patient charting, etc.) is unavailable, the process to continue documenting patient care and responses to that care revert back to the paper-based record. Once the EMR system is restored, the information from the downtime process shall be made a part of the EMR when appropriate (e.g., documents that are normally scanned).

XVII. Contents of the Legal Medical Record

The medical record shall include, at a minimum, the following items:

- Patient's name
- Address on admission
- Patient's telephone number
- Patient's date of birth
- Patient's next of kin
- Identification number (if applicable)
- Medicare number (if applicable)
- Medi-Cal number (if applicable)
- Hospital account number
- Social Security Number
- Age
- Sex
- Marital Status
- Legal Status

- Mother's Maiden name
- Place of birth
- Legal Authorization for admission (if applicable)
- School grade, if applicable
- Religious Preference
- Date and time of admission (or arrival for outpatients)
- Date and time of discharge (departure for outpatients)
- Name, address and telephone number of person or agency responsible for patient (if applicable)
- Means of arrival (for emergency room records)
- Name of person or organization transporting patient to the emergency department
- Name of patient's admitting/attending physician
- Initial diagnostic impression
- Discharge or final diagnosis and disposition
- Advance directives
- Allergy
- Alerts and reminders (see Section XV, "Designation of Secondary Patient Information," above)
- Analog and digital patient photographs (for identification purposes only)
- Anesthesia records
- Care plans
- Consent forms for care, treatment, and research
- Consultation reports
- Diagnostic images
- Discharge instructions
- Discharge summaries
- E-mail messages containing patient-provider or provider communications regarding care or treatment of specific patients
- Emergency department records
- Fetal monitoring strips from which interpretations are derived
- Functional status assessments
- Graphic records
- History and physical examination records
- Immunization records
- Instant messages containing patient-provider or provider communications regarding care or treatment of specific patients

- Intake and output records
- Medication administration records
- Medication profiles
- Nursing assessments
- Operative and procedure reports
- Orders for treatment including diagnostic tests for laboratory and radiology
- Pathology reports
- Prenatal and labor records (if applicable)
- Infant identification sheet (if applicable)
- Patient submitted documentation
- Patient education or teaching documents
- Patient identifiers (medical record number)
- Post-it notes and annotations containing patient-provider or provider-provider communications regarding care or treatment of specific patients
- Practice guidelines or protocols and clinical pathways that imbed patient data
- Problem lists
- Progress notes and documentation (multidisciplinary, excluding psychotherapy notes)
- Records received from another healthcare provider, if they were relied on to provide healthcare to the patient
- Research records of tests and treatments
- Respiratory therapy, physical therapy, speech therapy, and occupational therapy records
- Results of tests and studies from laboratory and radiology
- Telephone messages containing patient-provider or provider-provider communications regarding care of treatment of specific patients
- Telephone orders
- Trauma tapes
- Verbal orders
- Wave forms such as ECGs and EMGs from which interpretations are derived
- Any other information required by the Medicare Conditions of Participation, State provider licensure statutes or rules, or by any third-party payer as a condition of participation

REFERENCES

Title 22, California Code of Regulations (Title 22, CCR) Sections 70527, 70727, 70751, 71549
42 Code of Federal Regulations (42 CFR) Section 482.24, Medicare Conditions of Participation
DHS Policy No. 361.2, Notice of Privacy Practices