LAC+USC MEDICAL CENTER POLICY

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LEGAL HEALTH/MEDICAL RECORD	1/15/08	414
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Departments Consulted:	Reviewed & Approved by:	Approved by:
Health Information Management Information Technology Management	Health Information Committee Attending Staff Association Executive Committee Senior Executive Council	Chief Medical Officer Chief Executive Officer

PURPOSE

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

LAC+USC Medical Center will ensure a single medical record is initiated for each individual Medical Center patient for continuity of care and legal purposes.

LAC+USC Medical Center adheres to all state and federal laws as well as other applicable regulatory and accreditation requirements.

DEFINITIONS

"Legal Medical Record ("LMR)" means the collection of information concerning a patient and his or her health care. The information may be from any source and in any form, including, but not limited to print medium, audio/visual recording, and/or electronic display. Each medical record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. The LMR is that collection of information that is created and maintained in the regular course of LAC+USC Medical Center business, made at or around the time indicated in the documentation, made by a person who has knowledge of the acts, events, opinions, or diagnoses appearing in it, and can be certified by the LAC+USC Medical Center facility Record Custodian(s) as such.

The LMR generally excludes records from other providers (i.e. health information that was not documented during the normal course of business at a LAC+USC Medical Center facility or by a LAC+USC Medical Center provider). However, if information from another provider or healthcare facility, or personal health record, is used in providing patient care or making medical decisions, it may be considered part of the Designated Record Set, and may be subject to disclosure on specific request or under subpoena.

PROCEDURE

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 LAC+USC Medical Center hospital, clinic, or physician's office.

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 component of the LMR consists of patient information from multiple Electronic Health Record source systems, including but not limited to hospital information system, laboratory system, radiology system and intensive care system.

The paper chart shall contain, whenever possible, original reports. Shadow files maintained by some clinics or care sites, contain copies of selected material, the originals of which are filed in the patient's permanent medical record. 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 the LAC+USC Medical Center may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices.

III. 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,* sections 70749, 70527 and 71549, and the Medicare Conditions of Participation 42 CFR Section 482.24.

Additionally, all hospital records and hospital based clinic records must comply with the applicable hospital's Medical Staff 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/LAC+USC Medical Center

facility's healthcare 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.

IV. Medical Record Forms

Every new paper form and every revised paper form must be approved prior to use in the medical record by the Medical Center's medical record forms committee and shall be forward to the DHS ORCHID Enterprise Forms process. Paper forms should not contain any shaded areas. Acceptable alternatives to shading include bold text, italicized text, and underlining.

All new electronic medical record systems must also be reviewed and approved by the forms approval process *(i.e., Medical Center Forms or Charting Committee)*

Format requirements for medical records paper forms are listed in Medical Center Policy 409, Attachment A.

V. 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 Medical Center policies and procedures related to record retention.

Original hard copies of patient records may be destroyed once the record has been electronically replicated and stored, and 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 LAC+USC Medical Center record retention policies.

No original records will be destroyed until verification of the completeness and Quality control has been performed, including clarity of the scanned document.

VI. 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/LAC+USC Medical Center hospital information system.

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

VII. Printing Electronic Documents

Electronic medical record documents that reside in the hospital information system shall be printed and filed in the paper-based medical record only upon request or during downtime procedures; the request shall be made to the Medical Center HIM Director; the decision to print and file electronic medical record documents (ongoing) is reserved for authorized users. Electronic medical record documents shall be retained in the hospital information system to meet patient care, legal and accreditation requirements.

A. Health Information Management (HIM) shall print electronic documents and file in the paper-based medical record for authorized users that do not have computer access to retrieve such documents.

VIII. 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 shall remain 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 should be drawn through the incorrect entry, the correction dated, the 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 in (a), and re-scanning the document. The original document is then voided in the electronic system.

B. Documents that are created electronically must be marked "in error" and corrected by one of the following mechanisms:

1. 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.

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

3. 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 or designee.

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

5. The HIM 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 "lined 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. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

1. Identify the new entry as a "late entry".
2. Enter the current 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.
4. When making a late entry, document as soon as possible. There is no time limit for writing a late entry. However the more time that has elapsed, the less reliable the entry becomes.
5. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.
6. Document the current date and time
7. Write "addendum" and state the reason for the addendum referring back to the original entry.
8. When writing an addendum, it shall be completed it as soon as possible after the original note.

D. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and 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.

E. Cut, Copy, Paste Guidelines

1. The "cut and paste" functionality available in the EMR eliminates duplication of effort and saves time, but must be used carefully to ensure accurate documentation and must be kept to a minimum.

2. Copying from another clinician's entry: If all or part of an entry made by another clinician is used, the clinician making the entry takes responsibility for the accuracy of the entry incorporated into one's own documentation. Otherwise, the entry should be quoted directly from the original entry and should be attributed to the original author.

3. Copying tests results/data: If test results are cut and pasted into an encounter note, the date of the original test results should be noted.

4. The original source author and date must be evidenced in the copied information, with an attribution statement referring to the original document, date and author.

VIX. 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.

A. 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:

1. Preliminary versions of transcribed reports,

2. Photographs for identification purposes,

3. Audio of dictation or patient phone call,

4. Communication tools (i.e. patient lists, work lists, clinician in-baskets and messaging, sign out reports, FYI, etc.)
5. Protocols/clinical pathways, best practice alerts, and other knowledge sources.
6. Patient's personal health record provided by the patient to their care provider.
7. 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 exam is considered a component 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.

B. Administrative Data is patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include but are not limited to:
   1. Authorization forms for release of information.
   2. Correspondence concerning requests for records.
   3. Birth and death certificates.
   4. Event history/audit trails.
   5. Patient-identifiable abstracts in coding system.
   6. Patient identifiable data reviewed for quality assurance or utilization management.
   7. Administrative reports.

C. Derived Data consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples:
   1. Accreditation reports,
   2. Best practice guidelines created from aggregate patient data,
   3. ORYX reports,
   4. Public Health records, and

5. Statistical reports.

DOCUMENTATION CONTENTS OF THE LEGAL MEDICAL RECORD

The legal medical record shall include, at a minimum, the following items (if applicable):

- Name
- Address on admission
- Identification number (if applicable)
- Hospital Number / Universal Medical Record Number
- Social Security Number
- Age
- Sex
- Marital status
- Legal status
- Mother's Maiden name
  - (i) Patient Mother's maiden name
  - (ii) 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 of time of discharge (departure for outpatients)
- Name, address, and telephone number of person or agency responsible for patient
- Name of patient's admitting/attending physician
- Initial diagnostic impression
- Discharge or final diagnosis and disposition
- Advance directives
- Allergy
- Alerts and reminder (see "Alerts, Reminders, and Pop-Ups, "above)
- Analog and digit 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
- Emergency department records
- Fetal monitoring strips from which interpretations are derived
- Functional status assessments
- Graphic records

- History and physical examination records
- Immunization records
- 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
- Patient-submitted documentation
- Patient education or teaching documents
- Patient identifiers (medical record number)
- Photographs (digital and analog)
- Practice guidelines or protocols and clinical pathways that imbed patient data
- Problem lists
- Progress notes and documentation (multidisciplinary, excluding psychotherapy notes)
- Psychology and psychiatric assessments and summaries (excluding psychotherapy notes)
- Records received from another healthcare provider if they were utilized to provide healthcare to the patient (see "Continuing Care Records, "above)
- 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
- Standing orders
- Telephone messages containing patient-provider or provider-provider communications regarding care or 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 Medical Conditions of Participation, state provider licensure statutes or rules, or by any third-party payer as a condition of participation

REFERENCES

Health Insurance Portability and Accountability Act, 45 CFR 160-164
California Medical Information Act, California Civil Code Section 56 *et seq*.
Medicare Conditions of Participation 42 CFR Section 482.24
Business Records Exception, Federal Evidence 803(6)
DHS Policy No. 390.101, Legal Medical Record
Title 22, California Code of Regulations (Title 22, CCR) Sections 70749, 70527,70727,70751,71549

REVISION DATES

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