Office Safety
Policy & Procedure Manual

2011

Section E

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POLICY NUMBER	OS- E100
POLICY TITLE	**Medical Record Entries**
INITIAL EFFECTIVE DATE	01/00
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Policy

The patient visit shall be documented accurately in the medical record.

Procedure

A. Stamped signatures are not appropriate as author identification in the medical record.

B. The author may be identified by handwritten signature, initials, or unique electronic identifiers.

C. Errors are corrected according to legal medical documentation standards. There are no unexplained cross-outs, erased entries or use of correction fluid. All errors are singled-lined, initialed, with date and "error" noted. Both the original entry and corrected entry are clearly preserved.

Responsibility/Department Linkages

Physician(s) / Quality Assessment Department

POLICY NUMBER	OS- E101
POLICY TITLE	**Medical Record Filing and Retrieving**
INITIAL EFFECTIVE DATE	09/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

To have the medical record available for each encounter.

Policy

The medical record shall be available at each encounter.

Procedure

1. **Space Requirements**
   a) Allow adequate space for files to be properly aligned making it easier to read the patient name or file number. Open shelving is recommended, as it is space effective.
   b) There should be adequate lighting to allow personnel to read patient names and numbers on the files.
   c) Medical record locations must be secured and locked when not in use. Only approved personnel have access to the area, as maintaining patient confidentiality must be a prime concern.
2. **Filing Systems:**
   a) Section Guides: Regardless of the medical record system of filing, the file area has large guides designating the beginning and ending of an alphabetical section or numerical section. The more clearly sections are marked the more accurate the filing.
   b) Alphabetical or Numerical filing systems are convenient for the small physician office, as cross-referencing is not required.
   c) Serial and Serial Unit The medical record is assigned a new number each visit and any previous medical records are incorporated with the new chart. Requires an alphabetical or numerical system to retrieve charts.
   d) Unit: The medical record is assigned one unique identifying number, i.e. social security number, which stays with the patient for the duration of the time the patient is seen.
   e) Master Patient Index: The master patient index is a reference listing of all patients who have ever been treated at the office. The retrieval of any pre-

existing sting medical record information is dependent on an accurate master patient index that lists all patient encounters with the medical group. This index may be an alphabetical card file, microfilmed alphabetical list, or a computerized patient database.

3. **File Folders:**
   a) Legible Folders: The letters or numbers on the medical record folder should be large enough to be read from a distance. If the filing system is numerical at a minimum the patients' last name should appear on the folder as well for verification purposes.
   b) Color Coding: The outside edge of the medical record has color(s) coded to the last name of the patient or coded to the unique number assigned to the medical record. The advantage to color-coding is that is reduces the errors made in filing and facilitates faster medical record retrieval and filing.
   c) Out-guides: When a medical record is removed from the file, a placement card is put in its place. This alerts the person that the medical record is checked out and gives the location where the medical record may be found.
   d) Computer applications: Chart tracking by optical scanning or data input whenever a medical record changes location can be utilized.
4. **Encounters:**
   a) Each office should have a written procedure for the staff to follow outlining the different type of appointments (scheduled, urgent, and emergent).
   b) Medical records should be pulled a day in advance of the appointment. There are established procedures for requesting a medical record rather than everyone pulling their own.
   c) One staff members should be designated to pull and file the medical records.
   d) There is evidence that staff responsible for pulling and filing medical records has been trained in the proper rules of alphabetizing and instructed on the need to use out-guides and/or computer system to accurately record the most recent medical record location.

Responsibility/Department Linkages

Physician and office staff. / QA Assessment Department

POLICY NUMBER	OS- E102
POLICY TITLE	**Medical Record Maintenance**
INITIAL EFFECTIVE DATE	09/98
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

To maintain current information in the medical record to inform all care givers of the recent history, problems, allergies, medications, treatment plans, physical findings, laboratory and test results.

Policy

It is the policy to have a current medical record available for each patient visit.

Procedure

1) The content and format of medical records should be maintained in a uniform manner. The medical record should have a standard logical format with all pages affixed.

2) Medical record procedures relative to uniformity should include:
   a. How to initiate a medical record from a description of the outside cover of the chart to the title of dividers inside the chart
   b. A list of all documents by name in the order in which they should appear in the chart
   c. A description of a standardized medical record form
   d. Location of medical group name
   e. Location of patient I.D. information
   f. Description of chronological order of the chart e.g. straight date order or reverse date order

3) Data is added to the medical record in a timely and accurate manner
   a. Concurrent entries by the physician when examining the patient include: diagnoses, patient's condition and progress, follow-up plans, completed problem list and any final progress note
   b. Laboratory, x-ray, and diagnostic testing reports are available to the practitioner in a timely manner. There must be a unique identifier to ensure that the results have been reviewed by the physician
   c. Inpatient hospitalization documents are part of the office medical record and should be added to the record in a timely manner

4) Maintain all data in one folder to reduce the likelihood that vital information will be overseen
    a. When the chart becomes too thick, the staff will have a procedure for removing documents and noting the location in the chart
    b. When a medical record is requested, multiple volumes are pulled as needed

Responsibility/Department Linkages

Physician and office staff / QA Assessment Department

POLICY NUMBER	OS- E103
POLICY TITLE	**Medical Record Standards**
INITIAL EFFECTIVE DATE	01/01
REVISION EFFECTIVE DATE (S)	12/05
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

To ensure that medical records are in conformance with good professional medical practice and appropriate health management.

Policy

It is the policy to ensure that the medical record is maintained in a manner that is current, standardized, detailed, organized, and available to practitioners at each patient encounter and permits effective, quality care and service.

Procedure

1. Policy and Procedure
   Each practitioner office has a written Medical Record Policy and Procedure

2. Organization
   Each patient medical record will be individualized, format standardized, organized and secure.

3. Availability
   a. Each patient medical record will be filed and stored in a central place, utilizing a standardized and centralized medical group network tracking system assuring ease of availability and accessibility as well as confidentiality.

   b. Medical records will be transferred among practitioners when a member changes to a new PCP (prior to the member's first visit with the new PCP). The privacy of the medical record will be safeguarded in transit. Requested information will be delivered in a timely manner to ensure continuity of care.

4. Retention and Destruction
   Member medical information and records must be stored in an anonymous manner, and if disposed of, must be destroyed in a way such that information is not identifiable. It is CCHCA policy that medical records will be retained indefinitely to provide for retention of patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question.

5. Documentation

a. There will be a section for patient identification/personal biographical data inclusive of name, age, employer, occupation, marital status, work and home phone numbers, address, and insurance information.
b. Each page in the record will contain the patient's name or ID number
c. All entries in the medical record will contain the author's identification. Author identification may be a handwritten signature, initials—stamped signature, or a unique electronic identifier.
d. All entries will be dated.
e. All entries will be legible to someone other than the writer.
f. A problem list section will contain significant illnesses and medical conditions.
g. Each medical record contains the ID of all practitioners/providers participating in the patient's care, and information on services they render
h. Medication allergies and adverse reactions will be prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this will be appropriately noted in the record.
i. Prescribed medications, including dosages and dates of initial or refill prescriptions are noted
j. Past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
k. For patient 14 years and older, there will be appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen 3 or more times, substance abuse history will be queried).
l. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
m. Laboratory and other studies are ordered, as appropriate.
n. Working diagnoses are consistent with findings.
o. Treatment Plans are consistent with diagnoses and care is medically appropriate.
p. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed.
q. Unresolved problems from previous office visits are addressed in subsequent visits.
r. There will be documentation of appropriate use of consultants, and if a consultation is requested, there will be a note form the consultant in the medical record.
s. Consultation, lab, and imaging reports filed in the medical record will be initialed by the physician to signify review. Consultation, abnormal lab, and imaging study results will have an explicit notation in the record of follow-up plans.
t. Children and adult immunization records will be complete and current.

u. There will be evidence that preventive screening and services are offered in accordance with CCHCA's preventive care and practice guidelines. Health maintenance flow sheets may be utilized.
v. There will be evidence of continuity and coordination of care between practitioners and providers inclusive of between Behavioral Health Specialists and Medical Practitioners.
w. Each medical record contains documented evidence of PCP use of behavioral health practice guidelines (if applicable) in the form or preprinted behavioral health practice guideline in the medical record or PCP notation referencing the behavioral health practice guideline and that written guideline can be found in the PCP's office.
x. Each medical record contains Health Care Decisions Information
y. Each medical record containing progress notes indicating that a patient has been referred to a specialist, hospitalized, or had home health care will have corresponding specialist consultant reports, discharge summary or home health reports, as applicable.
z. Medical records of females age 47-57 contains evidence that the practitioner has communicated to them regarding their options for dealing with menopause.
aa. For members with documented diabetes: 1) the medical record contains a diabetes flow sheet, 2) practitioner is using established diabetes practice guidelines (copy in medical record or referenced and found in office), 3) medical record contains annual screenings for Hemoglobin A1c, LDL-C, Microalbuminuria, 4) medical record contains evidence of annual optometrist/ophthalmologist referral and reason for the referral.
bb. For members with documented heart disease: 1) the medical record contains a problem list noting the diagnosis of hypertension and including the date of diagnosis as an entry, 2) medical record contains a blood pressure reading after the date of entry of the diagnosis of hypertension on the problem list, 3) medical record contains evidence of a LDL-C screening performed after discharge for one of the following conditions/procedures: acute myocardial infarction, coronary artery bypass graft, and percutaneous transluminal coronary angioplasty.
cc. The patient's primary language, ethnicity, need for a translator or refusal to use a translator shall be noted on medical record.

Responsibility/Department Linkages

Medical Staff / Quality Assessment Department