TITLE: MEDICAL RECORDS

PURPOSE: To establish requirements for the University Health System (Health System) staff to ensure that each patients care is appropriately documented in a medical record to meet regulatory requirements. This policy applies to all Health System facilities regardless of location unless otherwise specified. This is a revised policy and supersedes policy dated May 09, 2011 [Key Words: Abbreviations, Medical Records, Physicians, Record Completion, Signature, and Supervision]

POLICY STATEMENT:

The Health System will maintain medical records that are accurate, timely, readily accessible, and permit the prompt retrieval of information.

POLICY ELABORATION:

I. DEFINITIONS

A. **Allied Health Professional (AHP) –** an individual, other than a licensed physician, dentist, podiatrist or limited licensed practitioner defined by state law, who exercises judgment within the area of his professional competence and the limits established by the Board of Managers, the Medical-Dental Staff, and the appropriate Texas state practice act; who is qualified to render direct or indirect care under the supervision or direction of a staff member possessing privileges; and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the Board of Managers, the bylaws, and the Medical-Dental Staff Rules and Regulations. An AHP is not eligible for staff membership.

B. **Attending Physician –** the active staff physician who has primary responsibility for a patient's treatment and care.

C. **Authorized Users –** all employees, contractors and other persons or third parties authorized to access or use health system protected health information.

D. **Chaplain-** a person who provides spiritual support to people of all faith traditions, explores spiritual questions and concerns that may arise during hospitalization.

E. **Corrections in the Medical Record –** a change in the information meant to clarify inaccuracies after the original electronic document has been signed or rendered complete.

F. **Electronic Medical Record –** a record of a patient's long-term and aggregate health information generated by one or more encounters in any care delivery setting and created from interoperability of multiple providers. The electronic medical record connects the various clinical systems and providers.

G. **Forms of Corrections Within the Medical Record –**

1. **Addendum:** An addendum is new documentation used to add information to an original entry.

2. **Amendment:** An amendment is documentation meant to clarify health information within a medical record. An amendment is made after the original documentation has been completed by the provider.

3. **Deletion:** A deletion is the action of eliminating information from previously closed documentation without substituting new information.

4. **Retractions:** A retraction is the action of correcting information that was incorrect, invalid, or made in error, by preventing display or hiding the entry or documentation from future general views.

5. **Late entries**: A late entry only applies to documentation within the electronic medical record that is entered after the point of care.

H. High-risk Procedure & Process – a process that, if not planned, or if not implemented correctly, has a significant potential for impacting the safety of the patient.

I. House Staff /Resident – a physician, dentist, or podiatrist participating in an accredited graduate training program whose practice requires supervision. The University of Texas Health Science Center at San Antonio must accept a person for clinical supervision by its active, provisional, or courtesy staff prior to a person's designation as House Staff.

J. Hybrid Medical Record – a record that consists of both paper and electronic media (film, video, or imaging).

K. Licensed Independent Practitioner (LIP) – any individual permitted by law and by the organization to provide care and services without direct supervision, within the scope of the individual's license and consistent with granted clinical privileges.

L. Medical Record – individually identifiable data in any medium, collected directly for the purpose of documenting health care or health status.

M. Medical Record Cloning – copying and pasting the patient information in an Electronic Health Record (EHR) from one date of service to another for the same patient. Documentation is also considered "cloned" when the medical documentation is exactly the same for different patients as may be documented through the use of templates.

N. Medical Student – an individual who participates in an allopathic or osteopathic educational program.

O. **Nurse Practitioner/Midwife –** a registered nurse approved by the Texas Board of Nurse Examiners to practice as an advanced practice nurse on the basis of completion of advanced educational program.

P. **Physician Assistant –** a person licensed as a physician assistant by the Texas State Board of Physician Assistant Examiners.

Q. **Practitioner/Provider –** a physician, dentist, or podiatrist appropriately licensed under the laws of the state of Texas to provide patient care services within the scope of the license.

R. **Scribe –** an un-licensed person who enters information into the medical record at the direction of a physician or licensed independent practitioner.

II. ELECTRONIC MEDICAL RECORD ACCESS

The electronic medical record will not be available other than as “read only” at day 60 following a patients discharge or encounter. Approval to unlock a medical record will be considered only for the purpose of amending incorrect information.

III. MEDICAL RETENTION AND DESTRUCTION

The Medical Records Department retains and destroys medical record information according to federal and state guidelines.

Destruction criteria are as follows:

A. **Inactive Records**: Patient records with no activity for 10 or more years.

B. **Active Records:** Patient records with activity within the past 10 years.

C. **Adult Charts:** The medical record of any patient may be destroyed on or after the tenth (10th) anniversary of the patient's last date of treatment.

D. **Pediatric Charts:** If the patient was under eighteen years old when he/she was last treated, the record may not be destroyed until the date of the patients twenty-first (21st) birthday or after the tenth (10th) anniversary of the date on which he/she was treated, whichever date is later in accordance with the Records Retention Schedules.

E. **Records that cannot be destroyed** include records of matters in litigation, those that have been requested by Legal Services to be placed in a "sensitive" status ("legal hold") or records with a permanent retention requirement. In the event of a lawsuit, legal hold or government investigation, the applicable records that do not have a permanent retention requirement shall not be destroyed until the lawsuit or investigation has been completed, or the legal hold released by Legal Services. Upon notification by legal Services that the litigation or investigation has been completed or the legal hold released, the non-permanent records may be destroyed in accordance with established record retention schedules.

Health System records must be destroyed in a manner that ensures the confidentiality of the records and renders the information no longer recognizable and cannot be reconstructed. The approved methods to destroy Health System records include, but are not limited to shredding, burning, pulping, and pulverizing. A Certificate of Destruction form must be approved and signed by the appropriate management staff and the Health System's Records Management Officer prior to the destruction of records. Health System records cannot be placed in trash receptacles.

IV. STANDARDIZED FORMAT

Templates used to document patient health information must be reviewed and approved by the Medical Records Forms Committee to ensure they meet facility standards.

V. DICTATION AND TRANSCRIPTION

Dictated documents must be reviewed, approved and signed by the author. Transcribed documents will be quality checked during the analysis process in the medical records department.

VI. USE OF CLONED DOCUMENTATION IN THE ELECTRONIC MEDICAL RECORD

The electronic medical record environment allows the function of copying and pasting information from one source to another. Providers must use this function with caution as documentation should always be recorded for each individual patient encounter. When copying and pasting information, the information must be evaluated and validated. (See Attachment II).

VII. MEDICAL RECORD MAINTENANCE

The Health System maintains a hybrid medical record system i.e., a record that consists of paper and electronic media, while it transitions to a full electronic medical record system. The purpose of this dual system is to provide a complete medical record at all times for direct patient care. In order to maintain continuity of care health information must remain accessible at all times.

If the patient's continuity of care is at a facility which has not yet implemented the electronic medical record, the patient record is stored and maintained at the facility in which the patient care was given. The only exception is that records of outpatient visits provided at the hospital will be maintained at the Robert B. Green Campus. To provide continuity of care, the Health System uses computerized clinical, patient

care, and chart tracking systems to provide practitioners ready access to all relevant patient information.

VIII. RECORD CONTENT AND COMPLETION REQUIREMENTS

Individuals authorized to document in the medical record must maintain a complete current legible medical record on each patient in accordance with Attachment I of this policy.

IX. PRACTITIONER SIGNATURE AND ID NUMBER

When documenting on paper, entries in the medical record must be signed, timed and dated by the person making the entry. The practitioner's signature must be accompanied by the exclusively assigned 5-digit practitioner identification number.

X. USE OF SIGNATURE STAMPS

The use of a rubber signature stamp is not acceptable.

XI. RELEASE OF MEDICAL INFORMATION

The Health System will release patient information in accordance with Health System policy on Uses and Disclosures of Protected Health Information. The written consent of the patient, or legal guardian of a minor or an incompetent adult, is routinely required for the release of medical information to any person, agency, or facility, including practitioners and other hospitals, unless otherwise specified by law. The Health System will charge a reasonable fee for provision of medical records to requestors in accordance with state law.

XII. OWNERSHIP AND CONTROL OF RECORDS

Medical records are the property of the Health System and may only be removed from the Health Systems jurisdiction and safekeeping in accordance with a court order, subpoena, or statute. No one may falsify or inappropriately alter information in the medical record, to include electronic devices containing health information.

XIII. INFORMATION ENTERED BY A SCRIBE (See Attachment III).

REFERENCES/BIBLIOGRAPHY:

The Joint Commission 2011 Hospital Accreditation Standards

2010 Bylaws of the Medical-Dental Staff, University Health System.

TEX. HEALTH & SAFETY CODE §§ 241.151 et seq. (Vernon 2001)

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VHA Handbook 1907.01 (August 25, 2006) pages 27 – 29
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Health Level Seven, Version 2.3. Ann Arbor, MI 1997.

Center for Medicare and Medicaid Services Teaching Setting Guidelines

Health System Policy No. 2.0802, Information Asset Security/Use, 5/27/10.

Health System Policy No. 2.14.0, Uses and Disclosures of Protected Health Information, 5/27/10.

Health System Policy No. 10.09, Consultative Services, 1/26/10.

The Joint Commission Position on the Use of Scribes, Perspectives-June 2011

OFFICE OF PRIMARY RESPONSIBILITY:

Senior Vice President/Chief Revenue Officer