OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 2: Clinical Support **POLICY: 2.014**

SUBJECT: **Medical Record - Handling, Transportation, and Maintenance**

POINT PERSON: **JONI DETRANT, DIRECTOR, HEALTH INFORMATION**

APPROVED: **GREGORY P. ROBERTS, SUPERINTENDENT** **DATE: JANUARY 17, 2013**

I. POLICY

The purpose of this policy is to establish uniform practices for the maintenance and handling of medical records at Oregon State Hospital.

II. DEFINITIONS

A. "Medical Record" means documentation about a patient's care and treatment that is contained in the blue binder or brown folders or in the electronic medical record Avatar.

B. "Protected Health Information (PHI)" refers to any individually identifiable health information, whether oral, or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Any data transmitted or maintained in any other form or medium by covered entities, including paper records, fax documents and all oral communications, or any other form, such as screen prints of eligibility information, printed e-mails containing identified individual's health information, claim or billing information, hard copy birth or death certificate are included. PHI does not include school records that

are subject to the Family Educational Rights and Privacy Act, or employment records held in the Department's role as an employer.

III. PROCEDURE

A. General

1. The medical record is the property of the hospital and shall be maintained for every patient admitted for care or evaluation in accordance with this policy and procedure, and as described in the Health Information Department Policy and Procedure Manual.

2. The medical record for each patient is established at the time of the first contact, and all subsequent contacts are maintained under the same number assigned at the original contact. (Note: effective 11/1/2011, patients discharged within the previous two years and all new patients were assigned new medical record numbers. The primary medical record number is the Avatar assigned number [8XXXX], however, they are still assigned an OP/RCS number due to other clinical systems [pharmacy and laboratory] not yet available in Avatar.)

3.

RESPONSIBLE POSITION(S)	ALLOCATED SECTION(S)
Office Specialist 2	All
All Staff	All
Health Information	All

B. Templates and Forms (electronic and paper)

1. Only forms approved by the Medical Records Committee shall be used by hospital staff to document in the medical record.

2. The originals of reports completed by hospital staff are filed in the medical record, unless otherwise noted on the form.

3. Forms shall be filed in the paper medical record according to the approved filing order. The approved medical record order can be found at: I:\PUBLICATIONS\MEDICAL RECORD SERVICES\MRS Policy and Procedure Manual.

4. The Health Information Department provides central dictation/transcription support for authorized or approved patient reports. This service is in addition to direct data entry by clinical staff, or use of approved electronic templates for documentation completion.

5. The Health Information Department processes electronic report templates by requesting clinical staff forward the templates to the email address, Transcription.OSH-MRS@dhsoha.state.or.us

   Templates are then processed in a standardize manner according to report type, and saved to the I:drive folder, “PDF Patient Reports.” Templates do not contain an electronic signature, so the final report is considered the paper copy, which must be printed and signed by the practitioner, and placed in the hard chart.

C. General Documentation

1. All handwritten entries in the paper medical record shall be legible and written in blue or black ink.

2. All entries in the medical record shall be dated (month, day, and year), timed, and authenticated by signature and working title – i.e., John Doe, MHT. The electronic health record provides this information when a document or order is finalized.

3. All entries placed in draft status within Avatar, the OSH electronic health record, are to be finalized within 48 hours.

4. Only symbols, abbreviations, and acronyms approved by the Medical Records Committee shall be used in the medical record. To reduce confusion, symbols, abbreviations, and acronyms shall be used sparingly. Abbreviations shall not be used when recording diagnoses. (See OSH Medical Record Policy and Procedure Manual policy A5.)

5. All hospital forms filed in the paper medical record shall include the patient's first and last name and medical record number on both front and back of the form.

6. The medical record shall include required documentation elements as defined in discipline manuals, and shall be recorded in accordance with time standards defined in the same.

7. Corrections to the paper medical record shall be made by the author by drawing a single line through the entry and initialing and dating the correction. No documentation shall be removed from the medical record, or no entries once made shall be made illegible. Late entries concerning the patient should be titled as such, with the date and time of note written included.

8. The identifying information of any other patient (such as name, initials or medical record number) may not be recorded in any other patient's medical record. It is acceptable to document the name and title of other staff in the medical record, if clinically appropriate.

9. Removable notes or Post-its shall not be used for documentation purposes. These are not a permanent part of the medical record, and shall not be retained.

D. Medical records or any other documents containing a patient's protected health information shall not be taken off the hospital grounds without prior approval.

1. Approval for removal of protected health information is not necessary when it is done for standard clinical reasons (i.e., medical appointments, emergency department visits, discharge planning, same-day court hearings).

2. OSH maintains web access for official e-mail (mail.dhs.oregon.gov). Some staff may have the option of reaching their computer desktop (including the Avatar electronic health record) remotely through the Citrix application (dhs.oregon.gov). This is the preferred means of accessing and utilizing patient PHI, and shall be utilized if at all possible before requesting approval to remove medical records from the supervisor, the CMO, and/or the Superintendent.

a. It remains permissible to access the PHI remotely for clinical reasons as before. This shall be done from an environment that assures confidentiality of PHI displayed on the screen. However, printing out PHI in a remote location is the same as removing it – this would require written permission and maintenance of such information in a separate, secure location. Any printing and removal of PHI shall be entered into the desk log immediately upon return to the facility. The desk log shall contain the name and medical record number

of the patient, along with the report title, date, and author of each of the individual documents removed.

b. Destruction of copies of PHI shall always occur at OSH using the secure bins provided – never at an off-site location.

3. No employee may remove any protected health information (PHI) from the hospital grounds unless they have first received written permission from their supervisor, and then the Chief Medical Officer and/or Superintendent.

a. To request approval, staff shall complete the form, "Request to Remove Documents Containing Protected Health Information (PHI) from OSH." A response shall be provided within three business days. The form is located at: I:\PUBLICATIONS\FORMS NONMEDICAL RECORD

PHI may be contained in many different electronic or paper forms, not just the medical record (Avatar or blue and brown charts). This includes patient lists, email strings which include patient names, and personal planners.

b. If an employee receives such permission they shall:

i. Follow minimum necessary rule, taking only such information as needed to perform office duties in the specific instance.

ii. Follow all provisions of policy and procedure and DHS-090-010, Transportation of Information Assets, which describes how an employee is to maintain control of PHI during transport (The link can be found at: http://www.dhs.state.or.us/policy/admin/security/090_010.pdf).

iii. Prior to removing any PHI from hospital grounds, staff shall keep a desk log itemizing the date and scope of the information being transported, and on which patients. The desk log shall be kept in the secure work environment, and must be available for supervisor review.

4. In case of an emergency transfer to an acute care medical hospital, the necessary documents shall be copied/printed from the medical record (paper and electronic) and sent with the patient. If this is not possible due to time constraints, information (PHI) may be faxed.

E. The Director of Health Information shall be contacted immediately for processing records in response to subpoena duces tecum, and no one is to produce a response to subpoena duces tecum unless specifically directed to do so by the Director of Health Information.

F. Medical record documents (paper) shall never be removed or separated from the medical record. When copies of documents are needed, the whole record shall be taken to the copy machine for copying. Documents shall be returned in the same order as received. Copies made of the original record shall be handled in the same manner as the original record. (See OSH Medical Records Policy and Procedure Manual policy 1.05)

G. Loose sheet documents shall be filed into the paper medical record within twenty-four (24) hours of receipt. Clinical staff who complete paper documents may file reports directly into the medical record.

H. Maintaining Medical Records of Inpatients on the Units – Office Specialist

1. It is the responsibility of the Office Specialist on each unit to implement this portion of the policy on maintaining the medical record on the unit.

2. Medical records shall be accessed on the patient's unit or treatment mall areas, except in limited circumstances. If any portion of the medical record must be temporarily removed from these areas, then it is the responsibility of the individual removing it to assure an out card/outguide is completed and used to identify the date the record was taken, the patient's name and Avatar medical record number, the name of who removed the chart, and location it was taken to. This guideline applies to the entire medical record (both current blue charts and old brown charts).

    a. The brown charts shall be filed in the designated consult rooms on each unit.

b. Any medical record temporarily removed shall be returned to its location the same day. The Office Specialist is responsible to follow up immediately on any chart not returned in a timely manner.

c. If, for any reason, the medical record or any portion thereof, is missing and cannot be located, the unit Nurse Manager and Health Information Department shall be notified immediately.

d. Each month the Office Specialist shall complete a chart check and provide the results to the Health Information Department to assure all medical records signed out to the units are present.

3. The Office Specialist shall be responsible for maintaining the record according to the approved record filing order.

a. To keep the medical record from becoming unmanageable, current treatment documents are to be systematically thinned from the blue chart and filed in the patient's brown chart according to guidelines in the Health Information Department Policy & Procedure Manual.

b. When a patient is being transferred to another Oregon State Hospital unit, the entire medical record shall be transferred with the patient. The Office Specialist on the receiving unit shall be responsible for ensuring that the total record is received with the patient.

c. The medical record shall be kept on the unit while a patient is on leave.

d. When a patient is discharged, the Office Specialist shall remove the paper portion of the record from the blue binder, attach the original Discharge Plan Details form and blue ID card, and send them to the Health Information Department with the complete medical record. Records of patients discharged shall be received in the Health Information Department within five (5) working days of discharge.

e. If a patient is placed on unauthorized leave, the record shall be held on the unit for seven (7) calendar days. After such time, the record shall be received in the Health Information Department within five (5) working days.

f. The Director of Health Information, or designee, shall meet with the Office Specialist from each program and shall review the medical record system on the unit. Guidance and support for the Office Specialist responsible for purging/ thinning records is available from the Health Information Department.

I. Maintaining Discharged Patients' Medical Records – Health Information Department

1. The Health Information Department shall monitor the receipt of all discharged patient medical records (including patients who left on trial visit, conditional release, or unauthorized leave), and shall notify the nurse manager and/or program director or his/her designee of noncompliance with the medical record policy on processing medical records on discharge.

2. The Health Information Department shall assemble, analyze, code, and monitor completion of medical records within thirty (30) days of patients' discharge. Discipline Chiefs and Program Directors shall be notified of records still incomplete after thirty (30) days.

3. Loose reports received in the Health Information Department shall be filed in the patient's medical record daily.

4. Only Health Information Department staff are responsible for removing and re-filing medical records from the central file areas. Records needed for patient care after hours are retrieved by Communications Center staff who shall follow the designated protocol per Health Information Department policy and procedure.

   Additional discharged patient records are maintained at secure long- term storage facilities operated by the Department of Human Services and Department of Administrative Services.

5. Medical records shall not be removed from Health Information Department file rooms without being replaced by an outguide indicating the patient's name and number, number of record

volumes, who has the record, the location of the record, and the date the record was removed from the file.

6. Medical records of discharged patients shall not be kept out of the files over twenty-four (24) hours. The Health Information Department shall periodically monitor the main file to request the return of records out of the file beyond twenty-four (24) hours.

7. Standards for record keeping shall be defined by the Health Information Department Director in collaboration with the Medical Record Committee. These standards for record keeping shall be defined in the Health Information Department Policy and Procedure Manual.

IV. ATTACHMENTS

Attachment 1 Request to Remove Documents Containing Protected Health Information (PHI) from Oregon State Hospital.

V. REFERENCES

The Joint Commission – Hospital and Behavioral Healthcare Standards Manuals
Center for Medicaid and Medicare Services 42CFR 482.61 - Medical Record Requirements for Psychiatric Hospitals
Oregon Administrative Rules, Chapter 333, Division 505, Health Division, Medical Records 333-505-0050.
Oregon Administrative Rules 943-014-0000 to 943-014-0070
DHS 090-010, Translortation of Information Assets

New OSH Policy