MADISON COUNTY PUBLIC HEALTH

NUMBER: CR 3	**ISSUED:** **01/04/2011**
SUBJECT: Legal Aspects of Documentation	**REVISED:**
	REVIEWED: 9/2011

SCOPE OF PRACTICE: All Staff

PURPOSE: To maintain clinical records for all patients in a systematic, confidential manner.

POLICY: Clinical records for Madison County Public Health are kept in accordance with the Iowa Department of Public Health recommendations for Legal Aspects of Clinical Records 11/85, Medicare Conditions of Participation, and **Health Insurance Portability Authorization** Act (HIPPA) Regulation.

PROCEDURE:

I. Identification

“Correct Patient Identification Is Basic
To Conveying Accurate Information”

A. On each sheet of the record, properly fill in the name of the patient and current date.

FOR HARD COPY:

II. Errors and Alterations

“One Should Never Erase Anything
On a Patient’s Record”

A. Draw one line through incorrect material. Write “error”, add the date and nurse’s signature, and then add the corrected material through an addendum. There will be no whiting out, pasting over, or erasure of errors.

“Records Which Have Been Altered For Any Reason,
However Innocent or Pragmatic,
Should Always Include Notations of the Date,
Reason For Change and Initials,
Or Signature and Position of Person Altering Record”

B. If the nurse has altered or omitted some information, it should be incorporated into the record as soon as possible. Below is the proper

method of recording out of sequence. Unlock the visit to be amended and place in the visit note:

- Date of Addendum
- Addendum to (date of omitted charting)
- Entry and Signature
- Document in the nurse's notes.

C. If a portion of the record is recopied, the original sheet is to be:
Dated
Marked re-copied
Reason for recopying documented
Signed by the person who recopied it
Stapled with the copy
Retained as part of the record

III. Completeness

"The Medical Record Should Be A Document Which Describes The Patient's Medical Event In A Systematic, Organized Manner, Including Patient's Problems, Reactions and Responses To Procedures, Medications, Diet and Treatment"

A. In addition to recording of nursing actions/interventions against the Patient's Nursing Care Plan, accurate, careful, pertinent observations (objective and subjective) are necessary to document patient response to nursing care. Whenever instructions are given, the results should be documented in the narrative at the time of the current visit or the next visit indicating what the patient did or did not learn, to whom it was taught, and any written instructions.

IV. Observations

A. Avoid general terms; i.e., in no apparent distress, less edema.

B. Avoid opinions and conclusions; i.e., do not chart that distention is moderate or marked, but measure circumference of abdomen at level of umbilicus, so if distention is increasing or decreasing the degree will be evident.

C. Avoid value judgments such as house was filthy – instead describe specifically what was seen; i.e., piles of unwashed clothes on chairs and stacks of unwashed dishes on table and counters.

V. Signature

"Anyone Who Signs A Document Is Presumed To
Have Read The Document And If One Places His
Signature Under Treatments, Medications, and Notes,
It Is Presumed That The Signer Has Personal
Knowledge Of The Information
Or Performed The Particular Procedure"

A. The nurse who signs his/her own printed recording takes responsibility for the content.

B. Whenever a nurse signs his/her name on a patient's record, he/she should use first initial, last name followed by RN or LPN. (RN or LPN are the only definitions to indicate the legal license to practice nursing.)

C. There should not be any blank spaces following any entry in the clinical record. The signature shall be recorded on the signature line and dated.

VI. Timeliness

"Medical Records Are Evidence Of Certain Events,
The Original Entries Are Made Concomitantly
With A Particular Event . . . "

A. Recording should be done on the patient's record on the day the visit is made or if made at the end of the day, recorded the next day within twenty-four (24) hours of visit.
B. Each entry should include the date and the time of the visit.

VII. Secretary's Responsibilities

A. The secretary, as well as his/her employer, is liable for the acts or omissions he/she commits or omits while acting in the employer's behalf.

"Telephone Orders
Are Given Only To The Registered Professional Nurse,
And Are To Be Signed Or Initialed By The Physician
As Soon As Possible."

B. Secretaries do not take verbal orders from physicians or their agents.

C. Secretaries do not sign nurses' signatures anywhere on the records.

D. The record is a legal document and the content confidential. Any break in honoring the confidentiality is unethical and can be the basis for litigation.

VIII. Physician's Orders

A. **Intermittent Physician Orders** (IPO)

"Telephone Orders
Are Given Only To The Registered Professional Nurse,
And Are To Be Signed Or Initialed By The Physician
As Soon As Possible"

1. Verbal orders must be received in the agency by an RN.

2. Verbal orders will be accepted only from the patient's physician (MD, DO), DDS, or a person authorized as his/her agent; i.e., a member of his/her staff, a hospital RN, or hospital social worker. If the RN questions the orders, he/she is responsible for verifying them directly with the physician.

B. Timeliness

1. The initial and subsequent Plan of Care should be signed and incorporated into the chart prior to billing.
2. Stamp agency name and date on the Plan of Treatment when it is received by the agency.

C. Signature
The only signature accepted on a Plan of Care or prescription form is the handwritten signature of a physician or his stamped signature which he/she has initialed. Do not write in the date for the physician.

D. Non-Physician Referrals
Referrals not signed by a physician are occasionally sent to an agency when a patient is discharged from an institution. One evaluation visit may be made on those referrals. Dependent nursing functions may not be performed without physician's orders.

E. Order Changes
One should clarify that the physician has deleted or changed an order when the orders are returned and are unclear. The procedure to clarify this situation is as follows:

Call physician or refax question to physician for clarification. Document information in the nurses notes and acquire a new order before any questionable order is started.

IX. Release of Information

A. Prior to release of any confidential information, the patient must sign a release of information form which includes:

1. The name of the agency releasing the information
2. The name of the person(s) and/or agency(s)/institution(s) to whom the information is being given
3. The date the release is signed
4. If the patient is a minor, the release of information must be signed by one of the parents or a legally appointed guardian. The exceptions to this requirement are if a minor is married or emancipated; i.e., self-supporting and living apart from the parents' residence.

B. Release of information authorizations are legally valid indefinitely. However, it is good practice to renew authorizations once a year.

C. The original should be retained in the patient's clinical record. A copy is usually accepted by agencies from whom information is being sent or requested. If an agency requires an original signature on the release, it will be necessary for the patient to sign a second copy.

D. It is proper for a nurse employed by an agency asking for a release of information to witness the patient's signature.

X. Release of Record From The Agency

"Usually, At Trial, The Original Record Is
Introduced Into Evidence, And On Motion Of One
Of The Parties To The Suit, The Original Record
Is Returned To The Health Care Provider
After A Copy Is Substituted For Filing In the Court Record."

A. In the event of litigation, anyone not directly associated with the nursing agency must have a subpoena or written authorization from the patient before he/she can read the record.

B. If the record is subpoenaed, request that the court accept a copy. If the court insists on the original, then retain a copy in the agency. The record may never be returned.

C. The physician should be notified immediately. All incidents should be reported to the Public Health Nurse Administrator, Public Health Nurse Supervisor, and the Board of Health.

"As In All Records, A Judge or Jury May Assume
A Nurse To Be Careless If He/She Writes On The
Chart In A Careless Manner And With Numerous
Spelling Errors. It Is Important To All Who Read
The Record To Derive The Meaning That Was Intended."

Reference:

MADISON COUNTY PUBLIC HEALTH AND LIFELINE – WINTERSET, IOWA

	ISSUED: 3-3-2009
POLICY: Records Retention	
CR 4	**REVISED:**
	REVIEWED: 5-4-2010; 5/3/11;9/2011

POLICY: The purpose of this policy is to define the proper storage, retention period, and means of destruction for several types of public health system records in accordance with federal and state laws and regulations. Proper storage and destruction of records serves to safeguard assets, maintain patient and employee confidentiality, ensure efficient access to stored materials, and provide for appropriate destruction of sensitive and outdated records. The recommended record retention periods for various types of records are covered by this policy and are alphabetized within the following categories:

Medical/clinical
Financial
General
Insurance
Grants and loans
Human resources/Risk management

Not withstanding any other provision of this policy, no record relating to a matter under government/internal investigation or audit shall be destroyed until the investigation or audit has been concluded.

Madison County Public Health will comply with all applicable federal and state laws to assure proper storage, retention, and destruction of public health system records.

PROCEDURE:

Definition of Record.

Evidence of something written, said or done in any form that can be retrieved at any time (i.e. letters, photographs, video recordings, electronic media).

General Storage Rules.

1. Maintain records in an appropriate storage form (i.e. paper, CD, computer disc) for the recommended length of time indicated by this policy or for a longer period of time if required by state or federal law.

2. Ensure records are complete and readable in their stored form or can be reproduced in a complete and readable form upon request.

3. Store all records in a manner that permits the efficient retrieval of stored records and the efficient return of records borrowed from storage.

4. Records required for audit purposes, whether stored electronically or in paper form, should be cross-referenced in a manner that provides a paper trail between the general ledger and the source documents.

5. Restrict access to stored records to those individuals who have an appropriate need and permission to retrieve the records.

6. Duplicate materials can be destroyed according to this policy once they no longer serve an administrative or clinical function.

Storage Media

Paper vs. Alternative Storage Media (i.e. CD, DVD, disc).

1. Confirm that records copied onto an alternative storage medium are complete and readable before the original paper record is destroyed.

2. Once records have been transferred, the original version can be destroyed according to this policy.

Computerized Data and Back-up Files.

1. Protect computerized data with password or code as directed by IDPH.

2. Retain computerized data through backup and storage capabilities to comply with this policy.

3. When possible, format stored data to any new hardware or software system that will replace an old system to allow for future retrieval of information. When not possible, make arrangements to store data in another form for the full retention period.

Considerations for Choosing Storage Media.

1. Ensure all authorized users can identify and retrieve information stored.

2. Ensure cost effectiveness based on retention period of records, maintenance necessary to retain the records and available storage space.

Record Destruction

Expiration of retention period.

Records in any storage media form may be destroyed when the record retention period provided for in this policy expires, unless a longer retention period is required under state or federal law.

Copied records.

Records in the original form may be destroyed when the original is copied onto an alternative storage medium in a complete and readable form.

Medical records.

If as a result of this policy the retention period for medical records is shortened, Madison County Public Health should consider whether or not it is necessary to provide reasonable notification to patients indicating the change in the retention period.

Never destroy records involving:

1. Matters in litigation, until the lawsuit has been finalized.
2. Matters under government investigation, Medicare audit or internal investigation, until investigation/audit has been finalized.
3. Matters under state audit, until audit has been finalized or until statute of limitations has expired.
4. An indefinite or permanent retention period.

On-site Destruction of Records.

Destroy records by shredding, burning, pulping, pulverizing, or by other means until there is no possibility of reconstruction in order to protect privacy and confidentiality. Do not place records in common trash receptacles unless the records are rendered no longer recognizable.

Record Retention Schedule

Medical/Clinical Record	Time	Authority
Admission records	3 years	
Appointment records	3 years	
Competency records, staff	3 years	
Consent forms	Maintain with medical record or 3 years after expiration for adults; 21 years after expiration for minors	
Correspondence (related to medical records)	Retain for same period of time as medical record	
Daily time sheets	1 year	
Patient sign in sheet	3 years	
Adult Records	10 years from the last date of service	Iowa Code § 614.1(9); 481 I.A.C. § 51.12; § 53.20; § 57.16(3)a; § 62.18(4)a; 441 I.A.C. § 79.3; 210 Ill. Comp. Stat. 85/6-17; 735 Ill. Comp. Stat. 5/13-2 12; 42 C.F.R.§ 484.48; 42 C.F.R. § 482.24;.60-62
Maternity / Pediatric Records	21 years from the last date of service, or until the minor reaches 18 years of age plus 3 years of service, or until the minor reaches 18 yrs of age plus 3 yrs	Iowa Code § 614.1(9); 614.8(2); 599.1; 614.1(12); 441 I.A.C. § 79.3; 735 Ill. Comp. Stat. 5/13-211
Vaccinations	Permanently, as part of the medical record or in an office file or the IDPH State Vaccine Registry	42 U.S.C. § 300aa-25
Medical waste destruction records	3 years	
Policies, clinical (discontinued or updated)	5 years for policies related to adult care; 21 years for policies related to pediatric care	
Staff schedules and monthly activity sheets	3 years	
Financial Records	**Time**	**Authority**
Accounts payable ledgers, subsidiary ledgers and schedules	7 years	

Accounts receivable ledgers, subsidiary ledgers and schedules	7 years	
Appraisal by internal or external appraisers	15 years	
Audit reports (external)	Permanently	
Audit reports (internal)	7 years	
Bank deposit slips	2 years	
Bank reconciliation	2 years	
Bank statements	7 years	
Budgets	5 years	
Cash receipts from donations	7 years	
Checks (canceled/voided) and check register/payroll	7 years	
Fee schedule records	7 years	
Financial statements (year-end, other optional)	Permanently	
Inventories of products, materials and supplies	7 years	
Invoices (to customers, from vendors)	7 years	
Payroll records and summaries	7 years, or indefinitely when required for a defined benefit plan	
Purchase orders (departments)	1 year	
Requisitions, purchase	1 year	
Voucher register and schedules	7 years	
Vouchers for payments to vendors, employees, et, (includes allowances and reimbursement of employees, officers, etc, for travel and entertainment expenses	7 years	
W9 forms	7 years	

General Records	**Time**	**Authority**
Accreditation Certificates	Permanently	
Annual Reports	Permanently	

Board of Health and PH Advisory Committee Bylaws	Permanently	IDPH Legal Counsel, 7/03
Articles of Incorporation, Bylaws, charters and minute books	Permanently	
Contracts and agreements (unexpired)	Permanently	49 C.F.R. § 379.13
Contracts and agreements (expired)	11 years	Iowa Code § 614.1(5); 735 Ill. Comp. Stat. 5/13-206; 49 C.F.R. § 379.13
Freight bills / records	1 year	49 C.F.R. § 379.13
HIPAA policies and records related to disclosure of protected health information	7 years (beginning April 2003)	45 C.F.R. § 164.528
License, certificates and permits of government approval	Permanently	
Meeting minutes (BOH)	11 years	
Meeting minutes, departmental, other committees	3 years	
Policies, general corporate (discontinued)	6 years	
Policies, compliance	Permanently	
Public relations (display advertising)	3 years	
Telephone Log	7 years	

Insurance Records	Term	Authority
Accident reports	6 years for adults; 21 years for minors	
Accident reports/claims (closed cases - non-professional negligence)	3 years	Iowa Code § 614.1(2); 735 Ill. Comp. Stat. 5/13-202
Accident reports/claims (closed cases - professional negligence)	11 years	Iowa Code § 614.1(9); 735 Ill. Comp. Stat. 5/13-2 12
Accident reports/claims (open cases)	Indefinitely	

Grant and Loan Records	Term	Authority
Community/Public Health Services Project Grants	7 years or until resolution of all issues	42 C.F.R. § 51c.l 12
Health Profession and Nursing Student Loan Programs	7 years or until resolution of all issues	42 C.F.R. 57.215

Human Resources	Term	Authority

Records		
ADA required records and notices	1 year	29 C.F.R. § 1602
Certificate of age - minor employees	3 years	29 C.F.R.§ 570.121; 29 C.F.R.§ 516.5; 41 C.F.R. § 150-201
Contracts, employees (expired)	11 years	Iowa Code § 614.1(5); 735 Ill. Comp. Stat. 5/13-206
Disability records	Permanently	
Employment applications of candidates not hired	1 year	
Family and Medical Leave Act records	3 years	29 U.S.C. § 825.500
Immigration Form 1-9	The longer of 3 years from date of hire (or rehire) or 1 year from date of termination	8 C.F.R. §§ 274a.2(b)(2)(i) and 274a.2(b)(3)
Job descriptions /job classifications	3 years	
Occupational exposure records	Duration of employment plus 30 years	Iowa Code § 88.5-6; 29 C.F.R. § 1910.1030
OSHA 200 or 300 Logs, or their equivalents	5 years	29 C.F.R. § 1904.6
Personnel files (terminated)	Permanently	
Training materials/ records • OSHA • all others	 · 30 years · 5 years	
Workers' Compensation records (no longer employed and decision is final)	3 years	
Workers' Compensation records (employed or no longer employed but record is open)	Permanently	

HIPAA	Term	Authority
Documents related to uses and disclosures	6 years	64 Fed. Reg. 59994 42 CFR Part 1003
Authorization Forms	6 years	64 Fed. Reg. 59994 42 CFR Part 1003
Business Partner contracts	6 years	64 Fed. Reg. 59994 42 CFR Part 1003
Notices of privacy practices	6 years	64 Fed. Reg. 59994 42 CFR Part 1003
Responses to a patient who	6 years	64 Fed. Reg. 59994

HIPAA	Term	Authority
wants to amend or correct their information		42 CFR Part 1003
Patient's statement of disagreement	6 years	64 Fed. Reg. 59994 42 CFR Part 1003
Complaint record	6 years	64 Fed. Reg. 59994 42 CFR Part 1003

MADISON COUNTY PUBLIC HEALTH WINTERSET, IOWA

NUMBER: CR 6	**ISSUED:** **1/4/2010**
SUBJECT: Documentation	**REVISED:**
	REVIEWED: 9/2011

SCOPE OF PRACTICE: Agency Director, Office Manager, Clinical Supervisors, Office and Patient Care Staff

PURPOSE: To provide guidance for staff on proper documentation as related to third party payers, conditions of participation, and legal aspects of charting. To provide a complete record of services provided to support billing activities.

POLICY: The home health record is a written account of the client's history, status, and progress. It contains a plan of treatment, physician orders (if needed), care plan, client care forms, business and financial data. The record is the database for planning individualized care for the client and serves to communicate information to all health professionals involved in the client's care. Proper documentation is the key necessary to justify reimbursement for third-party payers and is the key to the nurse and department's protection from liability. Confidentiality laws and **HIPAA** (Health Insurance Portability Authorization Act) protect all information in the record. All agency personnel are required to maintain all client information in confidence and release information only to those listed on the signed release or required by law.

Homemaker charts are maintained on paper and may be checked out of the office by the supervisor or case manager to perform home visits. Homemakers and aides may take the client's assignment sheet into the client's home to work from. Home care aide visit notes are maintained on paper and incorporated into the chart.

The following guidelines will be followed:

1. **The record must be accurate in all respects.**
2. **Charting errors are corrected according to departmental policy. (See Legal Aspects of Charting) At no time will white out be used.**

3. **Entries will be made in a timely manner, within 24 hours of the visit; every effort should be made to document in the home during the visit.**
4. **Contradictions or inconsistencies in the chart should be avoided.**
5. **Negative or derogatory comments about clients or other providers should not be made in the visit report.**
6. **All faxed documents shall have a cover sheet identifying the information as confidential and to whom the fax is directed.**
7. **Only agency approved standardized abbreviations will be used.**
8. **All phone conversations with the client, physician, or home care providers will be documented in the nurse's notes tab.**
9. **Any instructions given to the client including follow-up with the physician will be documented. The client's failure to keep the appointments or to carry through with instructions shall also be recorded.**
10. **Questionable actions or care given by another member of the health team should be handled through occurrence reports. The client's chart should contain documentation of phone calls or instructions given to a team member and any observations related to the client's condition.**
11. **The treatment week is Monday through Friday.**

Chart Maintenance:
Client records may be thinned periodically to aid in ease of record use and to prevent records from becoming cumbersome. The following sections may be thinned annually (with the most current form in the chart). These areas are thinned as new forms are incorporated into the chart:

Consent Form
Aide report forms
Nurses Notes

The following forms are never removed from the chart:

Client Intake Data
Living Will
Durable Power of Attorney
Discharge Summary

INSTRUCTIONS FOR COMPLETING CHART COMPONENTS

Intake Form/Referral:

Intake Form/Referral can be completed by an RN or Office Manager. All components of the form should be completed: client data, name, address, phone, **DOB** (Date of Birth), insurance, directions to home and include a brief history of the client's current medical condition, physician's initial orders and medications.

The following forms are provided for client information and signature. A copy of these forms are left with the patient in their blue folder:

Consent Form
Financial Forms / Medicare Screening
Advance Directives
On-Call Cell phone Information

SUPERVISION

- Used any time personnel are supervised during a visit according to policy (HCA every 2 wks, etc.)
- Complete:
  - Discipline Category
    Paraprofessional = Aide/Homemaker
    Nursing = RN, LPN
    Therapist = Physical therapy (PT), Speech Therapy (ST), Occupational Therapy (OT)
  - Discipline Supervised – Services Home Health Aide (HHA), RN, LPN, etc.
  - Employee (name)
  - Supervision Type: Orientation (new employees; supervision ongoing after orientation completed)
  - Supervision Method:
    - Direct: employee being supervised is present
    - Indirect: employee being supervised is not present
    - All to include,
      - Supervision Activity:
      - Supervision Category
      - Activity Supervised
      - Comment: any additional concerns or observations
      - Client response to aide services
      - Effectiveness of aide services including whether goals are being met
      - Subject matter of conferences and/or staffing with aide

- Introduction, instructions, demonstrations, and return demonstrations
- Revisions/additions to aide assignments, including notifying aide
- Review of aide notes on aide's visit form
- Review aide's care plan every 12 months and document on care plan
- Document supervision in care plan