

LEGAL MEDICAL RECORD STANDARDS

PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record. Patient medical information is contained within multiple electronic records 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 "*Legal Medical Record.*"

DEFINITIONS

Medical Record: The collection of information concerning a patient and his or her health care that is created and maintained in the regular course of UC__ business in accordance with UC__ policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

- The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.
- The medical record excludes health records that are not official business records of UC, such as personal health records managed by the patient.

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 information may be from any source and in any format, including, but not limited to print medium, audio/visual recording, and/or electronic display.

The Medical Record may also be known as the "**Legal Medical Record**" or "**LMR**" in that it serves as the documentation of the healthcare services provided to a patient by a UC__ hospital, clinic, physician or provider and can be certified by the UC__ Record Custodian(s) as such. .

The Legal Medical Record is a subset of the **Designated Record Set** and is the record that will be released for legal proceedings or in response to a request to release patient medical records. The Legal Medical Record can be certified as such in a court of law.

Designated Record Set ("DRS"): A group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity (e.g. the UC Medical Center) for each individual that receives care from a covered individual or institution. The DRS includes:

1. The medical records and billing records about individuals maintained by or for a covered health care provider (can be in a business associate's records);
2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. The information used, in part or in whole, to make decisions about individuals.

Any research activities that create PHI should be maintained as a part of the DRS and are

accessible to research participants unless there is a HIPAA Privacy Rule permitted exception.

Protected Health Information (“PHI”): PHI is individually identifiable health information that is transmitted or maintained in any medium, including oral statements.

Authentication: The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

Clinic Record / Shadow File: A folder containing COPIES ONLY of information from the medical record used primarily by clinicians in their office or clinic setting. These COPIES of the relevant documents from the original medical record are NOT part of the legal medical record.

Macros: Macros allow a provider to record and replay a series of typed characters or other keystrokes (e.g., hot keys, one or more keys at the same time, or one-word commands) in a manner that makes it possible for a physician or a provider to quickly document an entire medical note while avoiding the cost of transcription and/or the time of repetitive documentation.

POLICY / PROCEDURES

I. Maintenance of the Medical Record

- A. A Medical Record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient of a UC__ hospital, clinic, or physician's office.
- B. Currently, the Medical Record is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the Medical Record may physically exist in separate and multiple locations in both paper-based and electronic formats. (See Appendix A).
- C. 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 and/or a written or dictated summary or interpretation of findings.
- D. The current electronic components of the Medical Record consist of patient information from multiple Electronic Health Record source systems. The intent of UC__ is to integrate all electronic documents into a permanent electronic repository.
- E. Original Medical Record documentation must be sent to the designated Medical Records department or area. Whenever possible, the paper chart shall contain 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.

II. Confidentiality

The Medical Record is confidential and is protected from unauthorized disclosure by law. The circumstances under which UC__ may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices (*see*: Privacy Policy and Procedure No. _____, "Notice of Privacy Practices") and in other UC__ Privacy Policies and Procedures.

III. Content

- A. 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. Appendix A contains a listing of required Medical Record documentation content, and current electronic or paper format status.
- B. 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.
- C. All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name and a unique UC__ Medical Record number. Each page of a double-sided or multi-page forms must be marked with both the patient's full name and the unique Medical Record number, since single pages may be photocopied, faxed or imaged and separated from the whole.
- D. All Medical Record 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 the Medical Record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

IV. Medical Record vs. Designated Record Set

- A. Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health (medical record) information that is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual. In accordance with the HIPAA Privacy Rule, UC__ has defined a "designated record set" to mean the group of records maintained for each individual who receives healthcare services delivered by a healthcare provider, which is comprised of the following elements:

1. The Medical Record whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips when a written or dictated summary or interpretation of finding has not been prepared;
 2. Billing records including claim information; and
 3. All physician or other provider notes, written or dictated, in which medical decision-making is documented, and which are not otherwise included in the Legal Medical Record (e.g., outside records, email when applicable for treatment).
- B. The Medical Record generally excludes records from non-UC providers (i.e., health information that was not documented during the normal course of business at a UC__ facility or by a UC__ 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 UC__ Designated Record Set, and may be subject to disclosure on specific request or under subpoena. Disclosures from medical records in response to subpoenas will be made in accordance with applicable Campus policies.

V. Who May Document Entries in the Medical Record: Multidisciplinary Notes

Only the following types of UC__ employees and/or employees of UC__-contracted clinical and social services providers may document entries in the Multidisciplinary Notes section of the Medical Record:

1. Child Life Specialists
2. Clinical Social Workers
3. Dentists
4. Dietitians/Diet Technicians
5. Emergency Trauma Technicians
6. Fellows
7. Home Health Coordinators
8. Clinical Care Partners
9. Hyperbaric Technicians/Observers
10. Interns
11. Interpreters (Employees of UC__)
12. Lactation Specialists
13. Licensed Vocational Nurses
14. Medical Assistants
15. Medical Ethicists
16. Nurse Practitioners
17. Nurses employed by physicians (exceptions)
18. Occupational Therapists
19. Osteopathic Students
20. Pastoral Care Providers

21. Pharmacists
22. Physical Therapists
23. Physician Assistants
24. Physicians including MD's and DO's
25. Podiatrists
26. Psychologists
27. Registered Nurses
28. Mental Health Practitioners
29. Licensed Psychiatric Technicians
30. Midwives
31. Residents
32. Respiratory Therapists
33. School Teachers
34. Speech Pathologists
35. Students, e.g., MD, RN, Occupational Therapy, etc. (Notations in the record must be co-signed by a supervising clinician)
36. Students, e.g., MD, RN
37. Others as designated by Medical Center Policies and /or Medical Staff Bylaws

VI. Completion, Timeliness and Authentication of Medical Records

- A. All inpatient Medical Records must be completed within 14 days from the date of discharge (California Code of Regulations, Title 22, section 70751). Additional requirements may also be included in the applicable UC__ hospital Medical Staff By-Laws and/or Rules and Regulations.
- B. All operative and procedure reports must be completed immediately after surgery.
- C. All Medical Record entries are to be dated, the time entered, and signed.
- D. Certain electronic methods of authenticating the Medical Record, including methods such as passwords, access codes, or key cards may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with UC__ electronic signature standards (*See Section XII below: Authentication of Entries*). The entries may be authenticated by a signature stamp or computer key, in lieu of a medical staff member's signature, only when that medical staff member has placed a signed statement with the Medical Center to the effect that the member is the only person who: 1) has possession of the stamp or key (or sequence of keys); and 2) will use the stamp or key (or sequence of keys).
- E. Fax signatures are acceptable.

VII. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations ("TPO")

The Health Information Management Services staff will process routine requests for Medical Records. All charts physically removed from the Medical Record storage areas will be logged, e.g., using a computerized tracking system

Only authorized UC__ workforce members may access Medical Records in accordance with Privacy Policy and Procedure No. ____, “*Employee Access to Protected Health Information (“PHI”).*” UC__ Workforce members (as defined in Policy No. ____) who access Medical Records for payment or healthcare operations are responsible to access only the amount of information in medical records which is necessary to complete job responsibilities.

A. Access to Medical Records for Treatment Purposes.

Healthcare providers who are directly involved in the care of the patient may access the full Medical Record in accordance with Policy No. ____.

B. Payment Purposes.

Authorized and designated UC__ workforce members may access the patient’s medical record for purposes of obtaining payment for services, including the following uses:

1. Coding and abstracting;
2. Billing including claims preparation, claims adjudication and substantiation of services;
3. Utilization Review; and
4. Third Party Payor Reviews (including Quality Improvement Organization reviews).

C. Healthcare Operations.

Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:

1. Peer Review Committee activities;
2. Quality Management reviews including outcome and safety reviews;
3. Documentation reviews; and
4. Teaching.

D. Requests for Electronic Components of the Medical Record.

Personnel who access the electronic Medical Record are required to have a unique User ID and password, and access to information is limited according to the minimum necessary rule and managed by role, as approved by designated management personnel.

VIII. Ownership, Responsibility and Security of Medical Records

- A. All Medical Records of UC__ patients, regardless of whether they are created at, or received by, UC__, and patient lists and billing information, are the property of UC__ and The Regents of the University of California. The information contained

within the Medical Record must be accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative.

- B. Responsibility for the Medical Record. The UC__ Director of Medical Information (Health Information Services) is designated as the person responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other health care professionals are responsible for the documentation in the medical record within required and appropriate time frames to support patient care.
- C. **Original records may not be removed from UC__ facilities and/or offices except by court order, subpoena, or as otherwise required by law.** If an employed physician or provider separates from or is terminated by the University for any reason, he or she may not remove any original Medical Records, patient lists, and/or billing information from UC__ facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to UC__.
- D. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate. Records will be released from Health Information Management Services only in accordance with the provisions of this policy and other UC__ Privacy Policies and Procedures.
- E. Special care must be exercised with Medical Records protected by the State and federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing and AIDS research. (Refer to Policy No. _____. "*Authorization for Use/Disclosure of PHI*".)
- F. Chronology is essential and close attention shall be given to assure that documents are filed properly, and that information is entered in the correct encounter record for the correct patient, including appropriate scanning and indexing of imaged documents.

IX. 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 UC__ policies and procedures (see: "*Records Retention*" and No. ____, "*Records Storage and Destruction*"). The electronic version of the record must be maintained per the legal retention requirements as specified in Policy No. ____ (UC Campus) "*Record Retention*" or consult with Campus Legal Counsel.

- A. In the event that an original Medical Record cannot be located, a temporary medical record folder will be created as follows:
 - 1. All identified original documentation held for filing in the original record will be included in the temporary folder;

2. A notation will be made in the record by the Medical Records Department Supervisor or Manager that the record is a temporary chart being used until the original can be located;
3. As needed, online documents will be printed and filed into the temporary folder;
4. The temporary folder will be tracked in the computerized chart tracking system by means of a special volume number to distinguish it from the original and to indicate that it is a temporary chart;
5. Upon location of the original record, all material from both the original and temporary folder will be incorporated into the original folder, and the temporary folder will be removed from the computerized tracking system.

X. Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the destruction policy (refer to section IX).

Handwritten entries should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

XI. 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 should still be 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. Patients may request a medical record amendment and/or a medical record addendum. (*Refer to UC__ policy for handling patient requests for record amendment and record addendums.*)

A. Documents created in a paper format:

1. Do not place labels over the entries for correction of information.
2. If information in a paper record must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and signature of the person making the revision.
3. 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 (2), and rescanning the document.

- B. Documents that are created electronically must be 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 also make changes when a non-clinical error is discovered prior to signing (i.e., wrong work type, wrong date, wrong attending assigned). If the preliminary document is visible to providers other than the author, then this document needs to be part of the legal health record.
 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.
 4. Sometimes it may be necessary to re-create a document (e.g., wrong work type) or to move a document, for example, if it was originally posted incorrectly or indexed to the incorrect patient record.
- 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. The entry must be signed.
 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 longer the time lapse, the less reliable the entry becomes.
- D. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.
1. Document the date and time on which the addendum was made.
 2. Write “addendum” and state the reason for creating the addendum, referring back to the original entry.
 3. When writing an addendum, complete it as soon as possible after the original note.
- E. Errors in Scanning Documents
- If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:

1. Reprint the scanned document.
2. Rescan the document to the correct date or patient, and void the incorrectly scanned document in the permanent document repository.

F. 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.

1. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.
2. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.
3. 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.

G. Copy and Paste Guidelines

The “copy and paste” functionality available for records maintained electronically eliminates duplication of effort and saves time, but must be used carefully to ensure accurate documentation and must be kept to a minimum.

1. Copying from another clinician’s entry: If a clinician copies all or part of an entry made by another clinician, the clinician making the entry is responsible for assuring the accuracy of the copied information.
2. Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical-provider is responsible for ensuring the copied data is relevant and accurate.
3. Copying for re-use of data: A clinician may copy and past entries made in a patient’s record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.

XII. Authentication of Entries

A. Electronic signatures must meet standards for:

1. Data integrity to protect data from accidental or unauthorized change (for example “locking” of the entry so that once signed no further untracked changes can be made to the entry);
2. Authentication to validate the correctness of the information and confirm the identity of the signer (for example requiring signer to authenticate with password or other mechanism);
3. Non-repudiation to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).

At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.*

- B. Electronic signatures must be affixed only by that individual whose name is being affixed to the document and no other individual.
- C. Countersignatures or dual signatures must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations.
- D. Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.
- E. Rubber stamp signatures: *Refer to Section VI (D)*.
- F. Documents with multiple sections or completed by multiple individuals should include a signature area on the document for all applicable staff to sign and date. Staffs who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.
- G. No individual shall share electronic signature keys with any other individual.
- H. Macros & Checklists. Pre-printed forms, checklists, patient questionnaires, and word-processing macros can be used to supplement written or dictated notes. When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation, if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized, patient specific information that is sufficient to support a medical necessity determination. The note in the record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros which do not contain patient specific information. Medical record macros and checklists may be used to supplement provider written or dictated notes.

XIII. Designation of Secondary Patient Information

The following three categories of data contain secondary patient information and must be afforded 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 often are maintained at the department level in a separate location or database, and are retrievable only upon request. Examples:
 - 1. Photographs for identification purposes
 - 2. Audio recordings of dictation notes or patient phone calls.
 - 3. Video recordings of an office visit, if taken for other than patient care purposes

** Acknowledge that there may be older systems that do not have this capability. Future plans for all system to meet this minimum requirement.*

4. Video recordings/pictures of a procedure, if taken for other than patient care purposes
5. Video recordings of a telemedicine consultation
6. Communication tools (i.e., Kardex, patient lists, work lists, administrative in-baskets messaging, sign out reports, FYI, drafts of notes, or summary reports prepared by clinicians, etc.)
7. Protocols/clinical pathways, best practice alerts, and other knowledge sources.
8. A Patient's personal health record provided by the patient to his or her care provider.
9. Alerts, reminders, pop-ups and similar tools 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 notes detailing the exam, are considered as 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, public health records and statistical reports.

D. Draft Documents / Work in Progress. Electronic processes and workflow

management require methods to manage work in progress. These work-in-progress documents often are available in the system as “draft documents, viewable to a limited number of users. They generally are not viewable to clinicians until the document is sent for final signature. Draft documents are not considered an official medical record document until it has been signed by an authorized signer.

XIV. ENFORCEMENT, CORRECTIVE & DISCIPLINARY ACTIONS

Compliance with the above policy is monitored by UC__ Department of _____. Violations of any of the above policy will be reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with UC__ Medical Staff ByLaws, and Human Resource / Personnel Policies.

RELATED POLICIES

- *Each UC may insert a list of related policies and forms or include the list as a separate Appendix,*
- Authorization for Release of Information; and Access to the medical record
- Patient Requests for Record Amendment and Record Addendums
- Auditing of access to medical records
- “Notice of Privacy Practices”; and in other UC__ Privacy Policies and Procedures.
- “Authorization for Use/Disclosure of PHI”
- Employee Access to Protected Health Information (“PHI”)
- “Records Retention”
- “Records Storage and Destruction
- Verbal / Telephone Orders

APPROVAL

REVISION HISTORY

REFERENCES

Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164

California Medical Information Act, California Civil Code Section 56 *et seq.*

Medicare Conditions of Participation, 42 CFR Section 482.24

Title 22 California Code of Regulations, Sections 70749, 70527, and 71549

Business Records Exception, Federal Evidence 803(6)

California Code of Regulations, Title 22, Section 70751

California Healthcare Association Manual – Authentication sections

Appendix A
Documentation Contents of the Medical Record

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

- A. Identification information, which include but are not limited to the following:
- 1) Name.
 - 2) Address on admission.
 - 3) Identification number (if applicable).
 1. Medicare.
 2. Medi-Cal.
 3. Hospital Number
 4. Social Security Number.
 - 4) Age.
 - 5) Sex.
 - 6) Marital status.
 - 7) Legal status.
 - 8) Mother's Maiden name
 - (i) Patient's Mother's maiden name
 - (ii) Place of Birth
 - 9) Legal Authorization for admission (if applicable).
 - 10) School Grade, if applicable
 - 11) Religious Preference.
 - 12) Date and time of admission (or arrival for outpatients).
 - 13) Date of time discharge (departure for outpatients).
 - 14) Name, address and telephone number of person or agency responsible for patient.
 - 15) Name of patient's admitting/attending physician.
 - 16) Initial diagnostic impression.
 - 17) Discharge or final diagnosis and disposition.
 - 18) Allergy records.
 - 19) Advance Directives (if applicable).
 - 20) Medical History including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients a neonatal history.
 - 21) Physical examination.
 - 22) Consultation reports.
 - 23) Orders including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services.
 - 24) Progress notes including current or working diagnosis (excluding psychotherapy notes).
 - 25) Nurses' notes, which shall include, but not be limited to, the following:
 - i. Nursing assessment including nutritional, psychosocial and functional assessments.

- ii. Concise and accurate record of nursing care administered.
 - iii. Record of pertinent observations including psychosocial and physical manifestations and relevant nursing interpretation of such observations.
 - iv. Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
 - v. Record of type of restraint and time of application and removal.
 - vi. Record of seclusion and time of application and removal. (NPH)
- 25) Graphic and vital sign sheet.
 - 26) Results of all laboratory tests performed.
 - 27) Results of all X-ray examinations performed.
 - 28) Consent forms for care, treatment and research, when applicable.
 - 29) Problem List (outpatient records only).
 - 30) Emergency Department record.
 - 31) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.
 - 32) Operative and procedures report including preoperative and postoperative diagnosis, description of findings, technique used, and tissue removed or altered, if surgery was performed.
 - 33) Pathology report, if tissue or body fluid was removed.
 - 34) Written record of preoperative and postoperative instructions.
 - 35) Labor record, if applicable.
 - 36) Delivery record, if applicable.
 - 37) Physical, Occupational and/or respiratory therapy assessments and treatment records, when applicable.
 - 38) Patient/Family Education Plan (NPH Only)
 - 39) Clinical Data set from other providers.
 - 40) Master Data Sets (as applicable to record type) including but not limited to : MDS (Skilled Nursing), OASIS (Home Health), IRF and PAI (Rehabilitation).
 - 41) Patient Photographs when used for identification or treatment.
 - 42) Master Treatment Plan and Reassessment (NPH only).
 - 43) Discharge Instructions
 - 44) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on discharge and the recommendations and arrangements for future care. If applicable it shall include diet and self-care instructions.
 - 45) Copies of letters to patients.

- 46) Email communications between the patients and the provider regarding the care and treatment of the patient.
- 47) Telephone Encounters. Documentation is required for telephone encounters with patients and/or their caregivers, or other care providers that:
 1. Provide new or renewal of prescription for medications
 2. Alter the current plan of care, including treatments and medications
 3. Identify a new system or problem and provide a plan of care
 4. Provide home care advice for symptom/problem management
 5. Provide authorization for care
 6. Provides or reinforces patient education

Documentation should include the date and time of call, name of caller and relationship to patient (if different from patient), date and time of the response (or attempts to return call), the response given, and the signature and professional title of provider or clinic staff handling the call.

- 48) Primary Language

Appendix B
Medical Records Forms Standards

Appendix C
Abbreviations & Symbols

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