**POLICY TITLE: Legal Medical Record**

**Former Policy Title:**

**POLICY:**

The Legal Medical Record is the business record generated at or for a healthcare organization. It is the record that would be released upon receipt of a request. The legal medical record is the officially declared record of healthcare services provided to an individual delivered by a provider. As such, it must be maintained in a manner that follows applicable regulations, professional practice standards, and legal standards.

**SCOPE:**

This policy applies to the Legal Medical Record created and maintained by any Lancaster General Health (“LG Health”) facility and all those authorized herein to enter information into the Legal Medical Record.

**PURPOSE:**

To define the Legal Medical Record as required by Federal and State Law. To delineate documentation standards set forth by regulatory, licensure, and accrediting organizations for entries in and maintenance of the Legal Medical Record.

**REFERENCE:**

1. 45 CFR Part 164, Subpart E, section 164.501 Definitions (HIPAA Standards for Privacy of Individually Identifiable Health Information)

2. Fundamentals of the Legal Health Record and Designated Record set, published by the American Health Information Management Association, issued January 2003; updated February 2011. 3. 42 CFR Section 482.24 Conditions of Participation: Medical Record Services. 4. Licensure Regulations for General and Special Hospitals, Title 28 PA Code Part IV, Subpart A, Chapter 115 B, Medical Record Services

5. The Joint Commission *Comprehensive Accreditation Manual for Hospitals,* chapters on Management of Information (IM) and Record of Care (RC)

6. Pennsylvania Department of Public Welfare Medical Assistance Handbook Chapter 1101. General Provisions, Section 51, Ongoing responsibilities of providers

7. College of American Pathologists (CAP) Laboratory Accreditation Program checklist standard GEN.41077, Reporting Outside Results

**DEFINITIONS:**

**Legal Medical Record –** Regardless of medium (paper, microfilm, document imaging system, electronic) or physical location of storage (clinical department, off-site storage, optical disk, etc.),

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**POLICY TITLE: LEGAL MEDICAL RECORD**

the Legal Medical Record is the health record that is:

∙ Documented in the normal course of business (following normal routines) ∙ Kept in the regular course of business

∙ Made at or near the time of the matter recorded

∙ Made by a person within the business with knowledge of the acts, events, conditions, opinions, or diagnoses appearing in it.

Refer to **Exhibit A** for specific documents defined as the Legal Medical Record for LG Health. Refer to **Exhibit B** for specific documents defined as outside the Legal Medical Record for LG Health.

**INSTRUCTION:**

This policy should be considered in conjunction with the following hospital policies: Medical Record Forms Approval Process

Uses and Disclosures of the Medical Record

Patient Amendment of Medical Record Information

Refer to the Uses and Disclosure of the Medical Record Policy for all patient requests to access or obtain copies of their Legal Medical Record.

**PROCEDURE:**

The Legal Medical Record must be maintained in a manner that follows applicable state and federal regulations, accreditation standards, professional practice, and legal standards. The following guidelines are intended to insure adherence to these standards.

**Who May Document**

Entries in the medical record shall be made only by those individuals involved in the care of, or responsible for maintaining the medical record of, that specific patient. Those individuals shall include members of the Medical and Dental Staff or their designees involved in clinical management of the patient, hospital employees who provide patient care, individuals contracted by LG Health to provide patient care, students and faculty in an approved clinical rotation/practicum, and hospital administration.

**Medical Record Forms**

All forms used for the medical record, including print formats generated by clinical information systems, must be approved prior to use in accordance with Medical Record Forms Approval Process policy. This excludes forms from other providers.

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**POLICY TITLE: LEGAL MEDICAL RECORD**

**Patient Identification**

∙ Each form in the medical record or electronic record screen must identify the patient by name and either medical record number, encounter number, or contact serial number (CSN) ∙ If the paper or electronic record printout contains multiple pages, patient identification must be on each page.

**Timeliness of Entries**

∙ Documentation in the medical record should occur at or near the time of the events being recorded.

∙ All medical record entries should be signed/authenticated, dated with a complete date (month, day, year), and timed.

∙ All orders should be signed/authenticated, dated with a complete date (month, day, year), and timed.

∙ Narrative documentation should reflect the actual time the entry was made and not be documented as a block of time (i.e., 7-3). Time should be recorded as military time or designated as a.m. or p.m.

∙ Recording time as a block is acceptable on certain types of flow sheets in which the treatment can be delivered at any time during the shift.

∙ Assessment forms where multiple individuals are completing sections should have a date, time, and signature for each section.

∙ It is unethical and illegal to pre-date or backdate an entry in the medical record. ∙ Electronic record systems must date and time-stamp each entry as the entry is made. ∙ Every entry must have a system-generated date and time based on the current date and time.

**Permanency of Entries**

∙ Entries in the paper medical record should be made with black or blue permanent ink. ∙ Pencils, light color ink or felt-tip/water soluble ink should not be used.

**Authentication**

Every entry in the medical record must be authenticated (signed) by the author. This may be a hand-written or electronic signature.

∙ If hand-written, the signature should include the first initial, last name, and credential/title or discipline.

∙ Use of an electronic signature must adhere to the following requirements: ∙ The User will be set up with the appropriate role and privileges to use an electronic signature within the assigned information system application.

∙ The electronic signature is unique to the author and meets uniform guidelines for User

*Effective Date: 01/01/17 Author: Walton-Sweeney, Charlotte L Review History: 1/1/2014, 1/1/2015 Owner: Costella, Margaret F Revision History: 12/29/2011, 12/28/2012, 1/1/2016 Page 3 of 6*

**POLICY TITLE: LEGAL MEDICAL RECORD**

Identification and Passwords.

∙ Every use of an electronic signature documents the User identifier, date, and time of authentication. This will provide an adequate audit trail in the event of a dispute of authenticity.

∙ Any report, generated by or received by LG Health that is authenticated with an electronic signature will contain the authenticator's name, credentials, and document that the report has been electronically signed. Reports stating “reviewed by” or “signing provider” are not acceptable without additional verification and signature by the author.

∙ Initials may be used only when the complete signature of the individual recording by way of initials is clearly documented within the medical record with a cross-reference/legend to the recorded initials.

∙ Rubber signature stamps are not accepted as valid authentication.

∙ Countersignatures should be used as required by Pennsylvania state law as described in the Rules and Regulations of the Medical and Dental Staff.

**Abbreviations**

Only approved abbreviations should be used in the medical record. Abbreviations identified as “DO NOT USE” should not be used under any circumstance. The approved and “DO NOT USE” abbreviation lists are located on the LG Health StarNet site.

**Summary (Problem) List**

The medical record of patients receiving continuing ambulatory care services (e.g. Downtown Family Medicine, Walter L. Aument Family Health Center, Healthy Beginnings Plus, Lancaster General Medical Group (LGMG), etc.) shall contain a Summary List of significant diagnoses, procedures, drug allergies, and medications.

**Outside Laboratory Results**

The Medical Director of the Laboratories shall approve the list of outside laboratories that will be used by LG Health. The approved laboratories have been assessed for quality, are approved by the medical staff, and have the licensing and accreditation information on file in the LG Health laboratory.

Results from laboratory tests ordered from approved outside laboratories will be entered as discrete data elements in the legal medical record for LG Health (eHealth) in accordance with established guidelines and will include:

∙ Name of Outside Laboratory

∙ Collection Date and Time

∙ Result Date and Time

∙ Value

∙ Reference Range

*Effective Date: 01/01/17 Author: Walton-Sweeney, Charlotte L Review History: 1/1/2014, 1/1/2015 Owner: Costella, Margaret F Revision History: 12/29/2011, 12/28/2012, 1/1/2016 Page 4 of 6*

**POLICY TITLE: LEGAL MEDICAL RECORD**

The paper report will be scanned into the document management system and attached to the appropriate order within eHealth. Outside laboratory results that are not related to an existing LG Health order will be scanned in accordance with established document imaging procedures.

Laboratory results that are incorporated into the legal medical record of a private or affiliated practice utilizing eHealth cannot be directly controlled by the Medical Director of Laboratories; however, it is strongly recommended that those practices incorporate results only from laboratories that are accredited by an appropriate agency.

**Documentation Corrections, Late Entries, and Amendments/Addenda *Handwritten Documentation:***

***Documentation Correction (includes documentation errors/mistaken entries as well as items to be omitted on pre-printed order sets)***

∙ Do not use correction fluid or obliterate the original entry.

∙ Draw a thin pen line through the entry, assuring that the original documentation can still be read.

∙ Write “error.”

∙ Sign, dated and time the entry.

∙ Document the correct information.

***Late Entries***

∙ Identify the new entry as a “late entry.”

∙ Document the current date and time.

∙ Identify or refer to the date and incident for which the late entry is written. ∙ Sign the entry

∙ Document late entries as soon as possible to assure reliability.

***Amendments/Addenda***

∙ For patient-requested amendments to their legal medical record - Refer to the Patient Amendment of Medical Record Information Policy.

∙ For an addendum where the author identifies that a modification to their documentation is required (after authentication by signature):

▪ Document the current date and time.

▪ Document “addendum” and state the reason, referring back to the original entry.

▪ Complete the addendum as soon as possible after the original documentation has been made.

▪ Electronically or manually sign the entry.

***Electronic Documentation***

Correcting an error, amending or addending in the electronic health record (eHealth) follows the same basic principles as outlined above. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry, the original entry should be viewable, the current date and time should be entered, the individual making the change should be identified and the reason should be noted.

*Effective Date: 01/01/17 Author: Walton-Sweeney, Charlotte L Review History: 1/1/2014, 1/1/2015 Owner: Costella, Margaret F Revision History: 12/29/2011, 12/28/2012, 1/1/2016 Page 5 of 6*

**POLICY TITLE: LEGAL MEDICAL RECORD**

Providers and other staff documenting within eHealth should follow the guidelines established by Epic and LG Health (e.g., Provider/Nurse Training Manuals and associated Computer Based Learning (CBL) modules, Chart Correction Guide, etc.).

**Legibility**

∙ All entries in the medical record must be legible.

∙ Medical Staff, employees, or others authorized to document in the medical record that have poor handwriting should print all entries.

∙ If an entry cannot be read, the author, or a designee, should rewrite the entry on the next available line and denote the rewritten entry as “reviewed and verified” and date and sign the entry. The entry rewritten must be the same as the original.

**Documentation Content**

∙ Use language that is specific rather than vague or generalized.

∙ Record factual information, not assumptions or speculation.

∙ Documentation should be based on professional judgment, not personal opinion. ∙ Use quotation marks when quoting the patient.

∙ Make sure that the entry is complete, clear, and contains all significant information. ∙ When an incident/event occurs, document the facts of the occurrence. Do not document or refer to the existence of an Event Report.

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