

The Patient Record

Speaker: Sarah Cottingham

We will begin this unit with the definition and purpose of the patient record.

The patient record serves as the business record for a patient's encounter. This is a phrase regarding the business record. Within the medical record, it must contain the documentation of all medical services provided to a patient. It must include the following information: demographic data, as well as the documentation to support diagnosis, justify treatment, and record treatment results.

As a general rule each page in the patient's medical records should include the following information: name of the attending physician or provider, patient's name, patient's number, date of admission/visit, name of the facility, address of the facility, and telephone number of the facility.

Health care Documentation can be categorized health care documentation as information capture and report generation. Please make sure that you are familiar with these two terms.

Information capture is the process of recording representations of human thoughts, perceptions, or actions in documenting patient care, as well as device generated information that is gathered and/or computed about a patient as part of health care. For example: generating images through x-rays.

Report generation is the construction of a health care documentation (paper or digital); consists of the formatting and/or structuring of captured information.

These are fundamental rules in regards to the principles of documentation; I suggest that you become familiar with these principals as you will utilize them further during your educational program here at Indian Hills:

- 1) A unique patient identification must be assured with and across healthcare documentation systems.
- 2) Healthcare documentation must be accurate and consistent, complete, timely, interoperable across types of documentation systems, accessible at any time and at any place where patient care is needed, and auditable.
- 3) Confidential and secure authentication and accountability must be provided.

Now let's move on to the definition of **continuity of care**, which is also the primary purpose of the patient record. The primary purpose of the patient record is to provide continuity of care, which means documenting services so others have a source upon which to base care.

Secondary purposes of the Health Record include the following: evaluating quality of patient care, providing information to third-party payer for reimbursement, serving the legal interest of the patient,

facility, and providers of care, and finally providing the data for use in clinical research, epidemiology studies, education, public policy making, facility planning, and health care statistics.

The health record is also used as a personal or impersonal source of information. You will need to know the difference between personal and impersonal use of the record.

In **personal use**, the user requests access to a specific patient record, in other words they specifically ask for a certain person's record. An attorney requests copies of a specific patient record. **Impersonal use**, the user randomly selects the patient record. An example would be, if the Quality Improvement Managers needs you to pull records of patients with a diagnosis of Myocardial Infarction for a hospital audit.

Let's now move onto the ownership of the patient record. This is very simple rule to remember – whoever creates the record, owns the record. The health record is the property of the provider who creates the records. However, the patient has the right to access his/her record. The patient also has the right to amend inaccurate information.

The hospital inpatient record documents the care and treatments received by a patient while hospitalized. Due to privacy issues you will typically find the paper based patient record being stored at the nursing station during the patient's hospitalization. Some facilities will have lock-in wall desk cabinets that are located outside the patient room. If the patient record is electronic they must be password protected.

All hospital inpatient records have similar content. You will become more and more familiar with this content as this class progresses. With the record there are specific data elements; these include administrative data and clinical data. Administrative data includes demographic, socioeconomic and financial data. Whereas clinical data includes all patient health information obtained throughout the treatment and care of the patient. You will notice most of the clinical data has a health record form, diagnosis, or procedure linked to it.

We are now going to switch gears and focus on hospital outpatient records which are also known as ambulatory care records.

The hospital ambulatory care record must document all services received by patients. Services typically include ancillary services such as laboratory and x-ray.

As previous discussed the utilization of outpatient services has steadily increased due to the DRG system in the early 80s. Patients could no longer be admitted to hospital for routine services.

The physician's office record must document services received by the patient while being seen in the physician's office.

There are numerous alternate care settings where patients can receive care. The content of the health record of the alternative settings depends on the type of services delivered, accreditation standards,

state, and federal regulations. Be sure to review the typical clinical data forms that will be utilized for ambulatory care, behavioral health, clinical laboratory, home care, long term care, and surgical centers.

We will now move onto provider documentation responsibilities. It is imperative that you understand these important concepts regarding documentation. The Joint Commission states that “only authorized individuals may make entries in the patient record.” The American Health Information Management Association (AHIMA) recommends that “anyone documenting in the health record should be credentialed or have the authority and right to document as defined by the organization’s policy.”

All health care providers need to complete an orientation program that addresses the fundamentals of documentation practice and standards. The following phrase that you will hear quite often in health care – “If it was not documented, it was not done.” Remember, as we previously noted, the health record serves as the facilities business record.

You will need to know the following documentation principles:

All patient record entries require authentication which means an entry is signed by the author.

Each facility must require that the provider signed with their first initial, last name, and title/credential.

A countersignature is a form of authentication by an individual in addition to the signature by the original author of an entry. Countersignature is mandated by state law.

A telephone order (TO) is a verbal order from a physician, taken over the phone by a qualified professional. Telephone orders should be reserved for emergency situations only. Physicians are required to sign TO’s within 24 hours.

A signature legend is used to identify the author by full signature when initials are used to authenticate entries. Initials are used on flow sheets and medication records.

The facility must maintain an official abbreviations list, which includes medical staff approved abbreviations, acronyms, and symbols that can be documented in the patient record.

All entries in the patient record must be legible. If someone can’t read what the doctor wrote – don’t do it; ask for clarification.

Accrediting and Licensure agencies require the timely completion of documentation of entries.

Let’s discuss the patient’s history and physical examination (H & P) requirements. This is a very common health record form that you will become quite familiar with as the time frames associated with this form.

Medicare’s Conditions of Participation require that the H &P must be placed in the record within 48 hours of admission.

The Joint Commission requirements for the history and physical are 24 hours after admission.

Notice: the Joint Commission requirements are more stringent than the Conditions of Participation.

The Joint Commission requires patient records to be completed within 30 days after the patient is discharged, at which time they become delinquent records. You need to know how to calculate the **delinquent rate**; this is quite simple as you divide the total number of delinquent records by the number of discharges in the period. Did you notice I said that you have 30 days after the patient has been discharged – what are your thoughts on that one?

Once in awhile it is necessary to correct documentation in the patient record. This is called amending the patient record. It is important to note that the only person authorized to correct an entry is the author of the original entry. You will need to know the proper steps to amending an entry.

- 1) Draw a single line through the incorrect information making sure that the original entry remains legible.
- 2) Date, specify time, and sign the correct entry.
- 3) Document a reason for the error in a location as close to the original.
- 4) Enter the correct information as close to the original information as possible.

The term **audit trail** is a term that I would like you to become familiar with. Audit trail can be defined as a technical control created by an electronic health record system and consists of listing all transactions and activities that occurred. The listing contains the date, time, and user who performed the transaction. This is very important tool for the electronic health record, as it will tell you who has accessed what information within the health record of a particular patient.

So let's move on – How is the patient records created? We will start with Pre-Admission Testing which is also referred to as PAT. PAT incorporates patient registration information, as well as all testing such as lab and x-ray, into one visit prior to inpatient care.

Upon admission to the facility, the admitting department is required to enter your provisional diagnosis. If this helps in medical terms pro means before, so provisional means before you are admitted. This is the tricky part – the provisional diagnosis can also be called the working diagnosis, tentative diagnosis, admission diagnosis, or preliminary diagnosis. This diagnosis is obtained from the attending physician on admission.

During the admission process the patient or patient representative (the person who is legally responsible for the patient) signs the admission consent form to document what is referred to as the consent to treatment.

Each facility develops policies and procedures that define the organization of reports in the patient record.

Organizing inpatient records according to reverse chronological date order means that the most current document is filed first in a section of records. Discharged patient records are typically organized in chronological date order, with the oldest information filed first in a section.

We will now move onto primary and secondary sources of information. *For those of you who are in the HIT program, this is something that you will need to know for future use.* **Primary sources** are records that document patient care provided by a health care professional. These records include the following: patient records, x-rays, scans, EKG's, and other documents of clinical finding.

Secondary sources are defined as patient information which are abstracted from the primary source. Examples include indexes, registers, committee minutes, incident reports. We have previously discussed the incident report, which we'll note that it is also referred to as the occurrence report. The incident report collects information about potentially compensable events (PCE's). A PCE is an accident or medical error that results in personal injury or property loss. This is important to note – incident reports are never filed in the patient's record.

We will now discuss record formats. The first record format is the **source oriented** record, which is also known as "SOR" or the sectionalized record. This is most traditional record format in that it maintains reports according to sources of documents. It is arranged according to sections in chronological date order. Many times the record is divided by tabs with department names such as x-ray, lab, nursing, and so on. You would find all the information about x-ray, under the x-ray tab.

The second record format is the **problem oriented** medical record, referred to as "POR" or "POMR." This record system was developed by Dr. Lawrence Weed in the 60s – I think he might have been smoking a little weed when he developed this system as it is a very complex system. The POMR has four main components which consist of the database, problem list, initial plan, and progress notes.

The database includes a minimum set of data to be collected on every patient. The data to be collected on each patient includes the chief complaint (CC); present condition and diagnosis; social data; past personal, medical, and social history, review of systems; physical exam; and baseline laboratory data.

The patient's problem list can be found inside the front cover of the patient record. It acts as a table of contents for the patient record, and contains a list of the patient's problems.

The initial plan describes what actions that will be taken to learn more about the patient's condition and treat and educate the patient.

The progress notes are documented for each problem using the SOAP structure. **SOAP** stands for subjective, objective, assessment, and plan.

- **(S) is for subjective.** The subjective data is from the patient regarding how they are feeling.
- **(O) is for objective.** The objective data is the observations about the patient; it includes the physical findings such as lab or x-ray results.
- **(A) is for assessment.** The assessment includes the judgments, opinions, or evaluations made by the health care provider.

- **(P) is for plan.** The plan is the diagnostic, therapeutic, and educational plans to resolve the problem.

The third and last record format is the **integrated record**. The record arranges reports in a strict chronological date order.

Hint: You will need to know the three basic record formats, as well as their advantages and disadvantages. You will also need to know what SOAP is.

Automated record systems have begun to replace paper-based records. The automated record system will provide timely access to health information for health surveillance, resource planning and health care delivery. There are three types of automated record systems:

- The **electronic health record** which is also referred to as the computer-based record (CPR) is a collection of patient information documented by a number of providers at different facilities regarding one patient.
- The **electronic medical record (EMR)** is created on a computer using a keyboard, mouse, optical pen device, voice recognition system, scanning, or touch screen. Records are created using vendor software which also assists in provider decision making (alerts, reminders, clinical decision support systems, links to medical knowledge, etc.)
- The **optical disk imaging or document imaging** provides an alternative to traditional microfilm or remote storage systems because patient records are converted to an electronic image and saved on storage media such as an optical disk.
- A **jukebox** stores a large number of optical disks resulting in huge storage capabilities. It resembles that of a jukebox that was used in the old days for records.

You will also need to know about the **Computer Stored Ambulatory Record**, also referred to as COSTAR. **COSTAR** is an outpatient electronic record that was created at Massachusetts General Hospital. COSTAR is said to be one of the first electronic records systems. The goal of COSTAR was to improve the availability and organization of outpatient records.

Please keep in mind that the primary goal of both manual and electronic patient records is documentation of patient care.

We will now focus our attention to record retention laws. The Medicare Conditions of Participation (COP) require hospitals, long term care facilities, specialized providers, and home health agencies to retain medical records for a period of no less than five years. *You will need to know this for future use.*

State laws vary from state to state, and some states have established time frames which are based on the statute of limitations. The statute of limitations is referred to as the time period in which a person may bring forth a lawsuit. Record retention is also impacted by the state laws that govern the age of

consent which is also known as the age of majority, which means facilities must maintain records for a time period in addition to the retention law.

The major responsibility for an adequate patient record rests with the attending physician. The HIM Manager is responsible for educating physicians and other providers regarding proper documentation policies and procedures. HIM staff members assist in the design of patient record systems to facilitate sound medical record documentation practices and perform record completion tasks to ensure compliance with facility policies, and state and federal regulations.

The HIM department record completion tasks include record assembly, quantitative analysis, qualitative analysis, concurrent analysis, and statistical analysis.

Record assembly is simply the process of organizing the discharged patient record in the correct chart order.

Quantitative analysis is process of reviewing the patient record for completeness. For example if the patient had surgery is the operative report on the record. This also includes the process of chart deficiencies, such as a missing signature on a report. The best way to mark authentication deficiencies in the patient record is the use pressure sensitive colored tags to flag missing signatures.

Qualitative analysis is the process of reviewing the patient record for inconsistencies that identify an incomplete document. Examples include the use of abbreviations in the final diagnosis made by the physician on the face sheet.

Concurrent analysis is the process of reviewing the patient record while the patient is still hospitalized, rather than waiting until the patient is discharged. Thus the HIT professional would flag the patient records for the physician to complete during the patient stay versus waiting until the patient is discharged.

And finally, **statistical analysis** is the process of abstracting information from the patient record to create indexes and registers.