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	Record of Care, Treatment and Services	Date Effective:	December 17, 2015
	Policy: Medical Record Documentation	Date of Origin:	October 01, 2009
Approved By: Medical Records Committee, Administrative Policy Council	Date Approved:	November 30, 2015	

I. Purpose

The purpose of this policy is to establish parameters 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. This policy defines requirements for those components of information that comprise a patient's complete "legal medical record."


II. Policy

It is the policy of Connecticut Children's Medical Center and Connecticut Children's Specialty Group (Connecticut Children's) to maintain a medical record in accordance with the parameters described below for every individual who is evaluated or treated as an inpatient, outpatient, or emergency department patient of the Connecticut Children's.


III. Inclusion/Exclusion Criteria/Indications/Definitions

A. Definitions:

1. **Medical Record:** The collection of information concerning an individual and his or her health care that is created and maintained in the regular course of business at Connecticut Children's in accordance with Connecticut Children's policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the individual and made at or around the time indicated in the documentation.
 - a) 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.
 - b) The medical record excludes health records that are not created by Connecticut Children's unless there is an indication that the records were used in medical decision-making.
2. **Legal Medical Record (LMR):** The Medical Record that serves as the documentation of the healthcare services provided to an individual by the Connecticut Children's and can be certified for such purposes by the Connecticut Children's Medical Center Record Custodian(s) when necessary (e.g. subpoena response).
 - a) 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 an individual's medical records. The Legal Medical Record can be certified as such in a court of law.

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3. 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 Connecticut Children's) for each individual that receives care from a covered provider or institution. The DRS includes:
 - a) The medical records and billing records about individuals maintained by or for a covered health care provider.
 - b) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
 - c) The information used, in part or in whole, to make decisions about individuals.
 - d) 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.
4. Protected Health Information (PHI): PHI is defined as information, including demographic information, about an individual that 1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; 2) could be used, alone or in combination, to identify the individual; and 3) relates to (i) the past, present or future physical or mental health or condition of the individual; (ii) the provision of health care services to the individual; or (iii) the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records and health information maintained by Connecticut Children's about its employees in its role as an employer.
5. Authentication: The process that ensures that users are who they say they are. The intent is to prevent unauthorized people from accessing data or using another person's identity to sign documents.
6. 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.
7. Clinic Record/Convenience 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. Convenience copies may include previously scanned documents that are accessed via electronic systems.

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IV. Key Points

A. Maintenance of the Medical Record


1. The medical record is 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, microfiche and electronic formats.
2. The medical record contents can be maintained in either paper (hard copy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, and fetal monitor strips.
3. Original medical record documentation must be sent to the Health Information Management (HIM) Department. The paper chart shall contain documents deemed to be the original reports.

B. Confidentiality

1. The medical record is confidential and is protected from unauthorized disclosure by law. The circumstances under which Connecticut Children's may use and disclose confidential medical information is set forth in the Notice of Privacy Practices for PHI and in other Connecticut Children's privacy policies and procedures.

C. Content

1. Medical record content shall meet all state and federal, legal, regulatory and accreditation requirements including but not limited to Regulations of Connecticut State Agencies 19-13-D3(d) and D4a(d), and the Medicare Conditions of Participation 42 CFR Section 482.24, Joint Commission and Department of Public Health. The Records Retention Program Policy contains a listing of required medical record documentation content, and current electronic or paper format status.
2. Additionally, all hospital records and hospital-based records must comply with the applicable hospital's Medical Staff Rules and Regulations requirements for content and timely completion.
3. All documentation and entries in the medical record, regardless of format, must be identified with the individual's full name and a unique Medical Record Number (MRN). Each page of a double-sided or multi-page form must be marked with both the individual's full name and the unique MRN.
4. 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. Late entries should be made as soon as possible.


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D. Completion, Timeliness and Authentication of Medical Records

1. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined in the Medical Staff Bylaws and Rules and Regulations.
2. All medical record entries are to be dated, the time entered, and signed.
3. All medical record entries must be timely, accurate, objective, and professional and conform with the use of accepted abbreviations.
4. 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 the Connecticut Children's electronic signature standards (See Section I below: Authentication of Entries). The entries may be authenticated by 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 access code key (or sequence of keys); and 2) will use the access code key (or sequence of keys).
5. Fax signatures are acceptable only in unique circumstances when electronic signature is not available and only with the prior approval of the department chair or HIM Director.


E. Ownership, Responsibility and Security of Medical Records

1. All medical records of the Connecticut Children's patients (regardless of whether they are created at, or received by, Connecticut Children's), including but not limited to patient lists, and billing information, are the property of Connecticut Children's. The information contained within the medical record must be accessible to the patient and 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.
2. Responsibility for the medical record. The Connecticut Children's Director of Health Information Management (HIM) is 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 meeting the required time frames to support patient care in the medical record.
3. Original records may not be removed from the Connecticut Children's 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 Medical Center for any reason, he or she may not remove any original medical records, patient lists, and/or billing information from the


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Connecticut Children's 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 the Connecticut Children's.


4. 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 Department only in accordance with the provisions of this policy and other Connecticut Children's Confidentiality and Privacy Policies and Procedures.
 5. Special care must be exercised with medical records protected by Connecticut State law and federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected child abuse reporting, and HIV-antibody testing and AIDS research.
 6. 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.
- F. Maintenance and Legibility of Record
1. 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 Record Retention Policy.
 2. Handwritten entries should be made with permanent black or blue ink, with medium point pens. Gel pens are not to be used in record documentation. 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.
- G. Corrections and Amendments to Records
1. 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.
 2. 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.
 3. Documents created in a paper format:
 - a) Do not place labels over the entries for correction of information.

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- b) 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, time and the reason for the revision noted, and signature of the person making the revision.
 - c) 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
4. Documents that are created electronically must be corrected by one of the following mechanisms:
 - a) Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date, time created, and the electronic signature of the individual making the addendum.
 - b) Preliminary versions of transcribed documents may be edited by the author prior to signing. A HIM 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.
 - c) 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.
 - d) 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.
5. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:
 - a) Identify the new entry as a "late entry"

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- b) 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.
 - c) Identify or refer to the date and circumstance for which the late entry or addendum is written.
 - d) 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.
6. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.
- a) Document the date and time on which the addendum was made.
 - b) Write “addendum” and state the reason for creating the addendum, referring back to the original entry.
 - c) When writing an addendum, complete it as soon as possible after the original note.
7. Errors in Scanning Documents
- a) 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.
 - b) Electronic Documentation – Direct Online Data Entry
 - (1) Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.
 - (a) 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.


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H. Authentication of Entries

1. Electronic signatures must meet standards for:
 - a) 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);
 - b) 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);
 - c) Non-repudiation to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).
2. 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.
3. Electronic signatures must be affixed only by that individual whose name is being affixed to the document.
4. Countersignatures or dual signatures must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations.
5. 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.
6. 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. Staff who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.
7. No individual shall share electronic signature keys with any other individual.


I. Designation of Secondary Patient Information

1. 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: 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. It is acknowledged that there may be older systems that do not have this capability. Future plans for all

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system to meet this minimum requirement. Examples of secondary patient information include but are not limited to:

- (1) Photographs taken by the hospital photographer.
 - (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
 - (4) Video recordings/pictures of a procedure, if taken for other than patient care purposes
 - (5) 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.)
 - (6) Protocols/clinical pathways, best practice alerts, and other knowledge-based sources.
 - (7) A Patient's personal health record provided by the patient to his or her care provider.
- b) 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.
2. Administrative Data: patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include but are not limited to:
- a) Authorization forms for release of information
 - b) Correspondence concerning requests for records.
 - c) Birth and death certificates.
 - d) Event history/audit trails.
 - e) Patient-identifiable abstracts in coding system.
 - f) Patient identifiable data reviewed for quality assurance or utilization management.
 - g) Administrative reports.

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3. Derived Data: information aggregated or summarized from patient records so that there are no means to identify patients. Examples:

- a) Accreditation reports
- b) Best practice guidelines created from aggregate patient data.
- c) ORYX reports, public health records and statistical reports.

J. Enforcement, corrective & disciplinary actions

1. Compliance with this policy is monitored. Violations will be reported to the appropriate supervising authority and may be subjected to the performance improvement process, up to and including termination and/or restriction of privileges in accordance with the Connecticut Children's Medical Staff Bylaws, and Human Resources Policies.


V. **References**

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

- A. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191
- B. Federal Regulations 42 CFR Part 2
- C. Accounting of Disclosures of Protected Health Information HIPAA: §164.528
- D. Connecticut Code of Regulations,
 1. Chapter 899 PA 89-246/ Chapter 368x Title 42 of the Code of Federal Regulations - Confidentiality of Medical Record


VI. **Related Documents**

- A. Connecticut Children's Medical Center Related Policies:
 1. Abbreviations- Use of
 2. Rights to Accounting of disclosures of Protected Health Information
 3. Records Retention Program
 4. Release of Health Information
 5. Use and Disclosure of De-identified and Re-identified Protected Health Information
 6. Protection of Confidential Information
- B. Appendix A: Who May Document Entries in the Medical Record

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Appendix A: Who May Document Entries in the Medical Record

1. The following types of Connecticut Children's employees and/or employees of the Connecticut Children's contracted clinical and social services providers may document in the medical record in conformance with their role:
 - a) Child Life Specialists
 - b) Clinical Social Workers
 - c) Dentists
 - d) Dietitians/Diet Technicians
 - e) Emergency Trauma Technicians
 - f) Fellows
 - g) Home Health Coordinators
 - h) Clinical Care Partners
 - i) Hyperbaric Technicians/Observers
 - j) Interns
 - k) Interpreters (Employees of the Connecticut Children's Medical Center)
 - l) Lactation Specialists
 - m) Licensed Psychiatric Technicians
 - n) Licensed Vocational Nurses
 - o) Medical Assistants
 - p) Medical Ethicists
 - q) Mental Health Practitioners
 - r) Midwives
 - s) Nurse Practitioners
 - t) Nurses employed by physicians (exceptions)
 - u) Occupational Therapists
 - v) Osteopathic Students
 - w) Pastoral Care Providers
 - x) Pharmacists
 - y) Physical Therapists
 - z) Physician Assistants

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- aa) Physicians including MD's and DO's
- bb) Podiatrists
- cc) Psychologists
- dd) Registered Nurses
- ee) Residents
- ff) Respiratory Therapists
- gg) School Teachers
- hh) Speech Pathologists
- ii) Students, e.g., MD, RN, Occupational Therapy, etc. (Notations in the record must be co-signed by a supervising clinician)
- jj) Others as designated by Connecticut Children's Policies and /or Medical Staff Bylaws