PURPOSE

To ensure each medical record, whether paper, electronic or combination, contains information which identifies the patient, describes problems and needs of the patient, justifies patient care, and accurately describes care provided, results, and continuity among disciplines.

POLICY

Agency will initiate and maintain an individual and accurate medical record for each patient receiving care in compliance with all federal and state laws and regulations. The record may be in a paper, electronic or combination format.

The record will include, at minimum, the initial and subsequent assessments, the plan of care, identification data, consent and authorization and election forms, pertinent medical history, and complete documentation of all services and events including evaluations, treatments, and progress notes.

PROCEDURE

1. Each medical record will contain the following:

   1.1 Patient identification information:

   - Name
   - Gender
     Address
   - Phone number
   - Date of birth
   - Legal authorized representative (if any)
   - Height/weight as appropriate to patient care
     For emergency contact:
       Family member/caregiver's name
       Family member/caregiver's telephone number
       Physician's name

1.2 Patient's needs information, as documented in both initial assessments and ongoing assessments, which reflects:

- Patient history
- Dietary restrictions/nutritional requirements
- Home suitability/adaptability
- Safety measures required to protect the patient from injury
- Care provided by Agency and contracted personnel
- Date care provided
- Staff member who provided care
- An updated medication profile to include medication, allergies, and/or sensitivities
  Actual or potential drug/food interactions
- The dose, time, date, and any adverse drug reactions of every dose of medication administered by Agency staff
- Identification of individual administering the medication
- Patient's mental status
  Survivor risk factors

1.3 Justification of care information:

- Identity of others known to be involved in patient's care
  Instructions given to patient upon discharge from another facility (if any)
- Transfer summaries/records (if any) received from transferring agencies
- Description of the patient's functional limitations
  Description of the patient's activity restrictions
- A statement of any change in patient's condition
- A statement of the conclusions or impressions drawn from the assessment data
- Primary and secondary diagnoses related to the patient's care as assessed upon admission and updated during the course of care

1.4 Documentation of care provided:

- Identification of problems, needs, actions and goals
- Ongoing education of patients/caregivers
- Evidence of consent for care on admission and during the course of care
- Legible, complete, individualized, diagnostic, therapeutic orders, including, but not limited to, types of care and equipment needed, frequency of visits, and instructions for a timely discharge or referral
- Updated orders as obtained
- Actions/ interventions/ procedures
- Care provided through contracted services

1.5 Documentation / Communication for Continuity of Care:

- Conclusions of patient medication monitoring
- Results of all diagnostic and therapeutic procedures and tests performed
- Patient's response to care
- Any referrals to internal or external providers/agencies
- Notification to the prescribing physician of patient discharge
- A discharge summary when patient dies or is discharged
- Any summaries of care provided through contracted services

1.6 Written consent from patient/ caregiver

- Consent for treatment
- Financial
  authorization Release
  of records
- Services to be provided and estimated frequencies

1.7 Acknowledgments of the following:

- Patient's/ client's receipt of a copy of the Human Resource Code, Chapter 102, Rights of the Elderly
- Patient's / client's receipt of the agency's policy relating to abuse, neglect and exploitation of a patient/ client,
- Patient/ client agreement to services provided by the agency
- Right to confidentiality

2. If Agency is using an Electronic Health Record (EHR) system for a patient / client Agency may:

    2.1 incorporate and file in the patient/ client's EHR a signed paper record by preserving its electronic duplicate in the EHR; or

    2.2 maintain the patient/ client's record as a combination of a signed paper record and an EHR.

3. If Agency preserves an electronic duplicate of a signed paper record in a patient/ client's EHR, agency is not required to retain the signed paper record. Agency should have a system for verifying the accuracy of an electronically duplicated paper record before destroying it.

4. If Agency is utilizing an EHR system, Agency must provide surveyor access to all of its records as requested and readily provide the equipment and information necessary to assist the surveyor in the review process.