POLICY

High Peaks Hospice (HPH) will establish a clinical record that contains past and current findings for each individual admitted to HPH’s services.
1. Clinical Records will be maintained in hard copy and/or in electronic form depending on the nature of the document required for the record. The records will be kept in a place convenient to and easily retrievable by HPH staff.
2. A standardized format will be used throughout all clinical records.
3. Entries will be current, legible and recorded in dark ink to facilitate photocopying.
4. Entries will be signed and dated, including the time of day and authenticated.
5. The record will be completed in a timely manner.
6. Documentation will be accurate and readily available to the attending physician and HPH staff.
7. The record will be in a form that can be summarized for transfer of information for inpatient care, home care services and bereavement services as appropriate.
8. The record will be safeguarded against loss or unauthorized access or use. HPH will comply with the State and Federal requirements governing the disclosure of personal health information (PHI).
9. The record will be maintained by HPH for at least 6 years after death or discharge, or in the case of a minor, for three years after they would have attained majority (18 years old), whichever is longer.

PROCEDURE

1. Each clinical record will include, but not be limited to, the following:
   - Identification data
   - Signed certifications of terminal illness
   - Pertinent medical history and physical, including diagnosis
   - Signed consent, authorization and Medicare Election forms
   - Authorization to disclose protected health information
   - Medication profile, including allergies or sensitivities with patient’s responses
   - Authenticated medical orders
   - Copy of the Patient Bill of Rights and Patient Responsibilities statements
   - Advanced Directives
   - Initial and subsequent assessments (including hospice admission history, certification, and re-certification)
   - Initial and ongoing assessments of each discipline involved with care
   - Initial and ongoing assessment of pain
   - Home safety assessment and description of any safety measures required
• Interdisciplinary Plan of Care
• Interdisciplinary Team Updates to the Plan of Care
• Patient/Family Goals and Outcomes of data elements
• Signed and dated progress notes following each contact by employees and contracted staff, including the patient’s response to care or services and patient/family education
• Telephone Call Logs to record telephone contacts
• Inpatient record, subsequent to any inpatient stay
• Diagnostic and therapeutic procedures, treatments and tests and their results
• Transfer forms, summaries or copies of any records received from or sent to transferring organizations
• Hospice Aid logs and Volunteer logs
• Discharge summary

2. All clinical records shall be current. Entries are required to be made within 24 hours of collection of the data. All entries shall be legible, in black ink, signed, dated with month/day/year/time or signed electronically depending on the nature of the document. Entries will be signed with full signature and title, except where initials have been approved. All Interdisciplinary Team (IDT) members shall have the authority to make entries in the clinical record. Clinical Records will be accessible to staff on a need-to-know basis.

3. A standardized format will be used throughout the clinical record. Only approved abbreviations may be used (see attached list). Records shall be kept on required New York State Department of Health (NYS DOH) forms and Federal Medicare forms as well as on forms approved by HPH.

4. Correction of Errors
   A. Errors in manual clinical records are amended by drawing a single line through the error and initialing.
   B. Electronic forms will be corrected as follows:
      1) Report all erroneous entries to the supervisor of the individual who made the error.
      2) The supervisor will generate a data correction request and forward it to the Information Technician (IT).
      3) The IT will process the data correction request within 8 working hours of the receipt of the request in accordance with the electronic software procedures.
      4) It is the responsibility of the supervisor of the individual who made the error to ensure all information is up-to-date in the electronic medical record before the erroneous entry is corrected.
      5) The IT will keep a record of the data before the correction and after the correction.
      6) The IT will track and trend correction requests by team and staff, and will report to the appropriate supervisor and Executive Director repeated occurrences of compromised data integrity.
5. HPH has a zero tolerance policy for falsifying clinical records.

6. Manual records shall be kept in a secure file and locked to ensure confidentiality and to protect against loss, destruction, tampering and unauthorized use.

7. Billing and clerical staff shall have access to clinical records only as needed to complete their assigned duties.

8. Electronic clinical records will be maintained on a secure server in accordance with the HIPAA Security Policies.

9. Staff members are responsible for the security of workstations used for HPH business.

10. Records or parts of clinical records may be photocopied only for the purpose of providing information to physicians, insurers, or other providers involved in the care of or payment for the patient and only information necessary to the provision of care or payment may be copied.

11. Each office shall have access to a shredder for the purpose of destroying copies of confidential record information.

12. Information from the clinical record may be faxed only to a physician or pharmacy or to an office of HPH or other hospices concerning a patient from HPH where the identity and fax number of the receiving party are known to staff.

13. All staff members will be oriented as to how to protect this confidential information.
   A. Records will be secured, whether in paper or electronic form, by locking up the information while carrying it on a patient/office visit
   B. During a visit, only information relevant to that patient will be brought into/accessed in the home. Information on other patients will be kept in the car trunk or on the floor behind the driver's seat with the car locked.
   C. In the nursing home, the records will be kept in a secure location in the nurse's station. During a patient visit, only information relevant to the patient will be brought into/accessed in the room.
   D. RNs on-call are responsible to keep records in a secure, low traffic area of their home.

14. Information entered into electronic clinical records when not connected to the main server must be updated (replicated) twice a day (before 8:30 am and after 3:30 pm) to ensure accurate information is available to staff members.

15. Records will be routinely reviewed by the Patient Care Coordinator (PCC) or designee to assure current documentation, current physician orders, and to assess the completeness and accuracy of the record.
16. The patient’s manual clinical record is closed by the servicing office when the patient is discharged from service.
   A. The manual record may be kept in the servicing office until bereavement service for the family is completed and the documentation is added to the closed chart, which is usually thirteen months after date of discharge.
   B. If the patient is a live discharge, the record is closed by the servicing office and may be held for six months, unless the servicing office determines that the patient will no longer need HPH’s services or bereavement services for the family.
   C. The manual clinical record is forwarded to the Administrative Office for storage and disposal at the appropriate time.
      1) Billing documents are maintained by the Administrative Office and placed in a secure storage area
      2) Manual clinical records will be retained for at least a six (6) year period after death or discharge of a patient. Commercial insurance beneficiary’s records are maintained for ten 10 years.
      3) In the case of a minor who is discharged, records will be kept for at least a six-year period after discharge or, if the minor attains majority, for a three (3) year period thereafter, whichever is longer.
      4) Destruction of manual records after the appropriate time will be accomplished by shredding.
      5) When manual clinical records are destroyed the electronic record will be closed also.

17. Records of complaints and appeals shall be retained for three (3) years from resolution and shall be made available to the New York State Department of Health upon request.

18. The patient/authorized representative’s written consent is required for release of information not authorized by law. See HIPAA Privacy Policies for further information.

LAST REVIEW DATE:  IDT 12/27/17, Clinical Comm 02/13/18, BOD 03/26/18

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