SUBJECT: MEDICAL RECORD CHARTS

I. PURPOSE

It is the responsibility of the facility to provide a medical record for each Individual and safeguard the record and its content against loss, damage, tampering, and unauthorized use. Rules regarding control of the medical record have been established and are to be strictly adhered to by all hospital personnel.

II. AUTHORITY

Special Order 502.01, 506.01, Welfare and Institutional Code 5328-5330.

III. POLICY

The medical record is the treatment chart for the Individual. This chart shall remain intact and is maintained on the unit of residence. Original or duplicated material from the chart is not to be removed from the hospital, except under the control of the Health Information Management Department. This is to ensure compliance with confidentiality guidelines (see Administrative Directive No. 580). Overall quality and integrity of the chart is the responsibility of Program Management.

IV. METHOD

A. The chart is a confidential document to be used for official purposes by authorized personnel only. It is admissible as a legal document only if the hospital can show that it has not passed from its direct, immediate and continuous control. The Medical Record is not to leave the facility except under court order.

B. The following terms are synonymous for the purposes of this directive: medical record, clinical record, patient record and chart.

C. The chart shall not at any time be taken to such public places as the dining room, canteen, or lobby. Its contents should not be discussed with or in the presence of unauthorized persons.

D. Microfilmed and electronic charts are considered the same as "hard copy" charts.

E. Changes and guidelines for the chart are issued as needed by the documentation committee.

F. Order of filing is designated in each chart and will be adhered to by all hospital employees.

G. Newly received medical record documentation will be filed in the Medical Record in a timely manner. Once filed, medical record documents are not to be removed from the patient's chart unless there is a compelling reason to do so (e.g., process a photocopy request). When necessary to temporarily remove a document from the chart, the document is to be handled with care: removal and replacement of staples; prompt re-filing of the document into the correct section of the clinical record.

H. When an Individual is discharged or placed on a leave of absence, the clinical record may be retained on the unit for a period not to exceed three (3) days. It is expected that all shift personnel will have completed all chart entries required within this time frame. The clinical record must then be returned to the Health Information Management Department file room.

I. Program Directors are accountable for the integrity of the charts while in the programs.

V. MEDICAL RECORD FILE ROOM CONTROL

A. No person other than those authorized by Health Information Management Department (HIMD) shall withdraw charts from the file room. The only exception to this rule is:

1. Saturdays, Sundays, holidays, and after-hours, the Police Services Watch Commander may authorize withdrawal of charts in conjunction with the Nursing on Duty (NOD) after ascertaining that the request for a chart is urgent and should be honored. The Police Services Watch Commander shall escort the NOD into the files area. The NOD shall properly prepare a withdrawal card (out guide) for each chart withdrawn and place it in the spot in the file room from which the chart was withdrawn.

2. Police Services and the NOD shall return charts withdrawn under this exception to the designated area of the main file room when the specific purpose for the chart withdrawal has been fulfilled.

B. Only authorized hospital personnel shall remove inpatient charts from the units. Personnel withdrawing charts shall prepare a withdrawal card (out guide) for each chart and place it in the spot in the unit office from which the chart is withdrawn.

C. Charts must be returned at the end of the day. When returning the chart remove the outcard and draw a single line through your name to indicate the chart was returned.

D. Charts must remain in plain view on desk or tabletops at all times. Never place charts in the desk drawer or out of sight.

E. All inpatient charts shall be returned to the units by 1630 hours each day. Under no circumstances will an employee in his or her office or other location retain a chart overnight. At change of each shift unit staff shall account for charts.

F. Department of Health Services (licensing) has legal authority to access records at any time:

1. They must sign the record review log for each record they review.

2. Charts must remain within the facility.

3. In cases of health emergencies, the chart will be returned to thetreatment team as soon as possible.

G. Copies of subpoenaed records are mailed to the superior court. When an original record is required in court the HIMD Director or designee takes the chart and a certified copy to the proceedings. The original chart returns with the Director or designee and the certified copy is left at the court if needed.
This function is handled by HIMD.

H. Original records only leave the hospital when they accompany the Individual when transferred to another state mental health hospital or are required at a court appearance.

Hospital ernployees receiving duly executed subpoenas shall review the patient's record prior to making a court appearance. The subpoenaed individual may request HIMD to provide photocopied portions of the patient's medical record for reference. Upon conclusion of the court action, any copied materials are to be disposed of by shredding.

HIMD Legal Section shall process all subpoenaed records prior to release to the court.

I. Only authorized hospital personnel may move charts <u>within</u> the hospital.

J. Individuals may transport their own chart to and from the clinic in a locked red bag.

W. T. VOSS
Executive Director

<u>Cross Reference(s)</u>:
A.D. No. 580 - Patient Medical Records: Confidentiality and Information Release, Maintenance, Retention and Disposition
A.D. No. 581 - HIPAA Patients' Access to Medical Record