AHC Media

August 10, 2016

Record of Care: Ensure Your Hospital's Compliance

Speaker

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Objectives

- Describe TJC-required elements found in the record of care chapter that should be incorporated into hospital forms and documents.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

Introduction to the RC Chapter

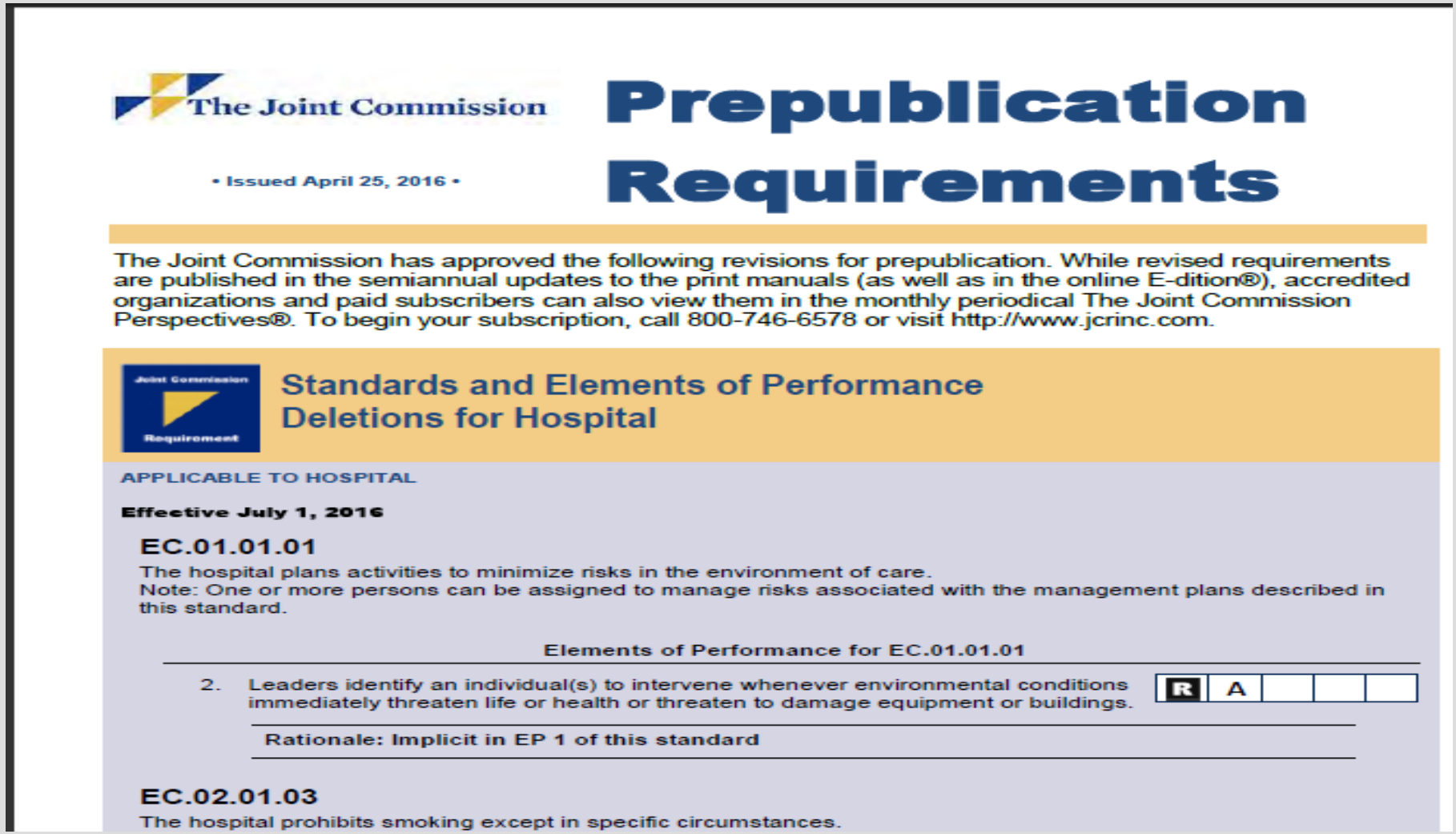
Record of Care Chapter

- New chapter in 2009 called “Record of Care, Treatment, and Services”
- Also referred to as the Documentation Chapter
- Abbreviated RC Chapter and includes 9 standards with 8 changes July 1, 2016
- Most sections came from PC and IM chapters
- Two of the RC standards have been top problematic standard for hospitals over the years
  - RC.01.01.01 will be discussed in more detail later

29 Provision of Care EPs Deleted

- The Joint Commission deleted **131** requirements that were identified as having become a routine part of operations and clinical practice
  - Or no longer necessary for quality or patient safety
  - Some were covered elsewhere
  - Effective July 1, 2016
  - Called Project Refresh
- Will delete a total of **225** requirements all together
- These deletions were the result of a multi-phased project to improve the accreditation and certification process

131 EPs Deleted July 1, 2016



The Joint Commission

• Issued April 25, 2016 •

Prepublication Requirements

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical The Joint Commission Perspectives®. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

Standards and Elements of Performance Deletions for Hospital

APPLICABLE TO HOSPITAL

Effeetive July 1, 2016

EC.01.01.01

The hospital plans activities to minimize risks in the environment of care.
Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

Elements of Performance for EC.01.01.01

2. Leaders identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten to damage equipment or buildings. R A

Rationale: Implicit in EP 1 of this standard

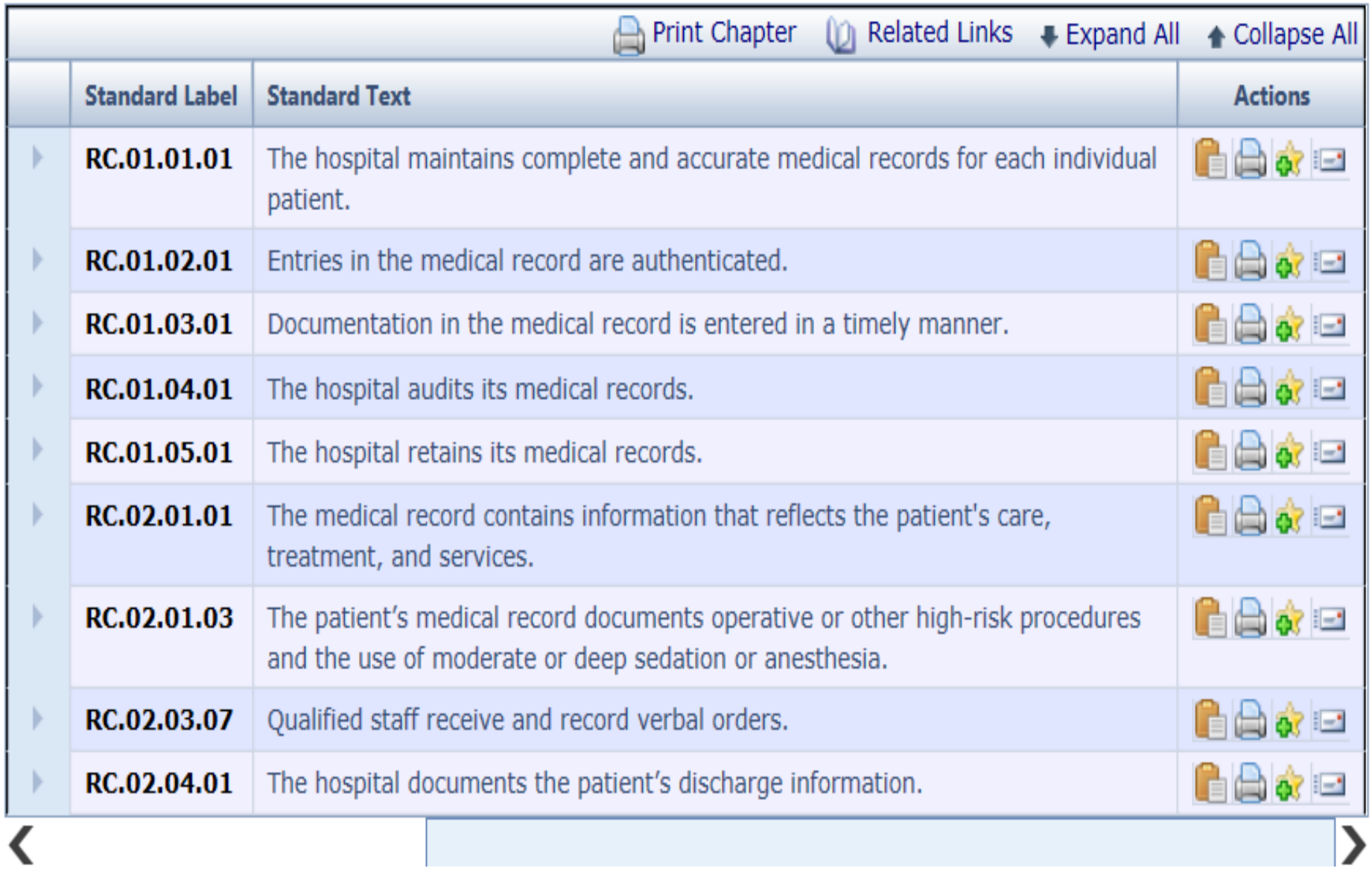
EC.02.01.03

The hospital prohibits smoking except in specific circumstances.

July 2016 Changes to RC Chapter

Record of Care, Treatment, and Services (RC)	
❑ Chapter Outline: Removed all references to standards not applicable to hospitals ❑ RC.02.01.01, EP 2: Deleted cross-reference to PC.01.02.01, EP 4, in third bulleted item; deleted cross-reference to PC.01.02.03, EPs 7 and 8, after last bulleted item ❑ Deleted the following requirements: ▪ RC.01.01.01, EPs 4 and 13 ▪ RC.01.04.01, EPs 3 and 4 ▪ RC.02.01.07, EPs 1–4 (entire standard)	Effective July 1, 2016

Record of Care 9 Standards



Print Chapter | Related Links | Expand All | Collapse All

	Standard Label	Standard Text	Actions
▸	**RC.01.01.01**	The hospital maintains complete and accurate medical records for each individual patient.	
▸	**RC.01.02.01**	Entries in the medical record are authenticated.	
▸	**RC.01.03.01**	Documentation in the medical record is entered in a timely manner.	
▸	**RC.01.04.01**	The hospital audits its medical records.	
▸	**RC.01.05.01**	The hospital retains its medical records.	
▸	**RC.02.01.01**	The medical record contains information that reflects the patient's care, treatment, and services.	
▸	**RC.02.01.03**	The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.	
▸	**RC.02.03.07**	Qualified staff receive and record verbal orders.	
▸	**RC.02.04.01**	The hospital documents the patient's discharge information.	

TJC Revised Requirements

- TJC has made many changes in their standards over the past years since they must reapply for deemed status
  - Purpose is to bring their standards into closer compliance with the CMS hospital CoPs
  - TJC applies to CMS now for deemed status
  - Sign up for free publications at www.jointcommission.org

CMS Hospital CoP on Medical Records

The CMS Conditions of Participation

- CMS also has a medical record section so any hospitals that accept M/M patient must follow this even if accredited by TJC
- Called the CoP or SOM manual
- First, published in the Federal Register[1]
- Then CMS publishes Interpretive Guidelines and some have Survey Procedures
  - Final interpretive guidelines issued November 20, 2015 and updated more frequently

[1]www.gpoaccess.gov/fr/index.html

CMS Hospital CoPs Medical Records

- Changes to interpretive guidelines posted on the CMS website [1]
- Hospitals should check the below website once a month for changes
- Section on **Medical Records** starts at tag number A-0431
  - Some sections overlap with standards in the TJC RC Chapter
  - Have required things that need to be documented in the medical record

[1] www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual

Appendix

Email questions to CMS at hospitalscg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

CMS Hospital CoP Manuals new address

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

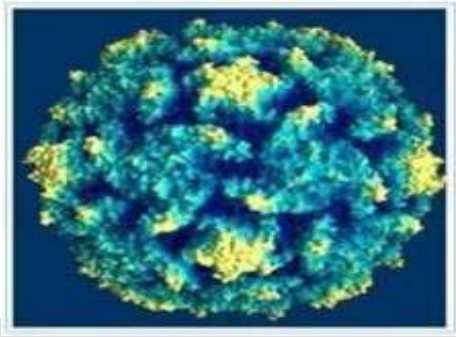
CoP Manual Also Called SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

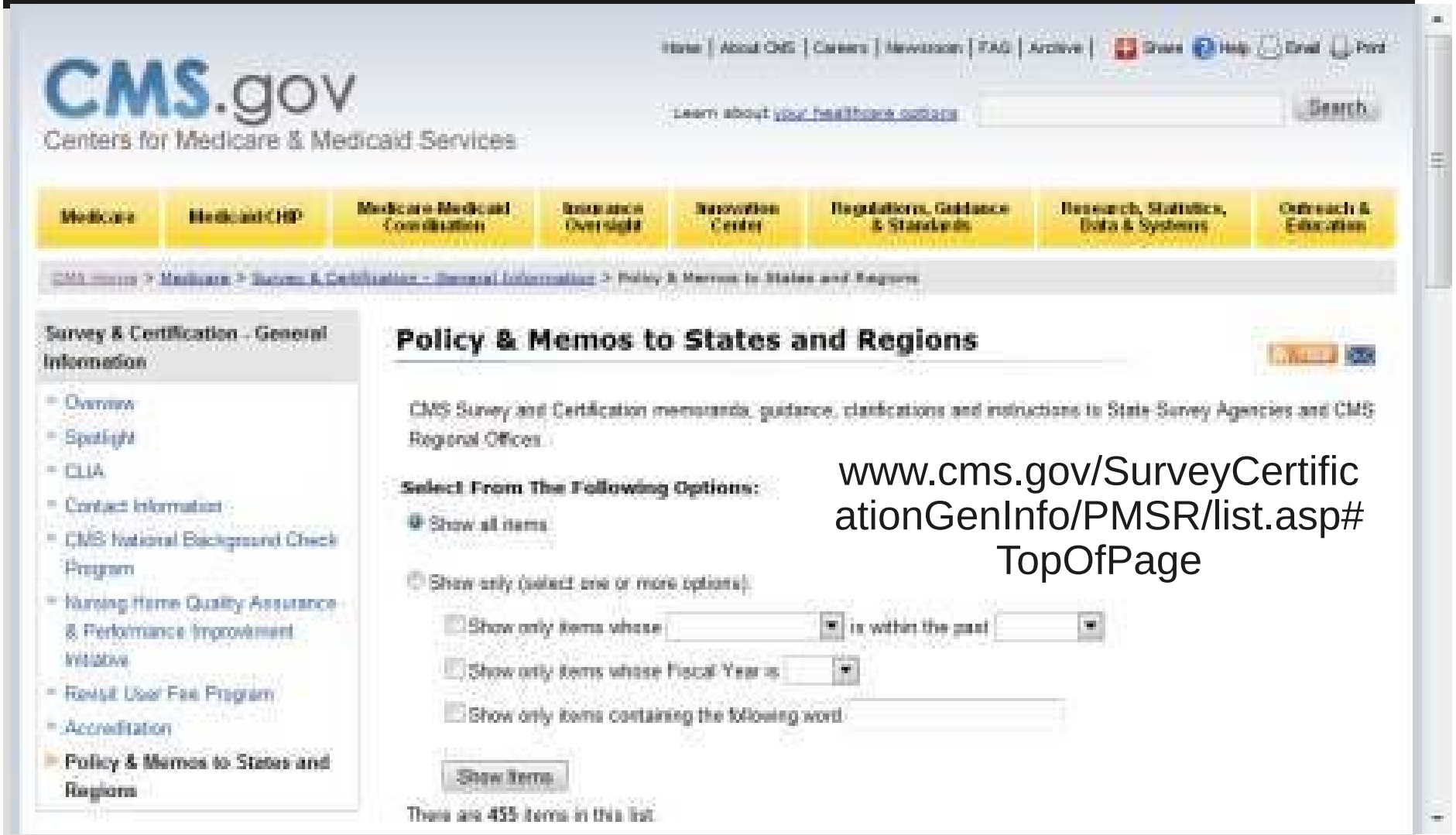
Table of Contents
(Rev. 151, 11-20-15)

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.p

Email questions
hospitalscg@cms.hhs.gov



CMS Survey and Certification Website



www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Survey Memos

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Certification Number (CCN) State Codes –State Operations Manual (SOM) Section 2779A Revisions	16-09-ALL	2016-03-11	2016
Advance Copy – Interpretive Guidelines for the Organ Transplant Conditions of Participation (CoPs) at 42 Code of Federal Regulations (CFR) §§ 482.68 through 482.104	16-10-Transplant	2016-03-11	2016
National Downtime of the Quality Improvement and Evaluation System (QIES)	16-12-ALL	2016-03-11	2016
Critical Access Hospital (CAH) Recertification Checklist for Evaluation of Compliance with the Location and Distance Requirements	16-08-CAH	2016-02-12	2016
FY 2015 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program	16-07-AO	2016-01-29	2016
Medicare Learning Network (MLN) Infection Control Courses	16-06-ALL	2016-01-22	2016

A-0431

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

Interpretive Guidelines §482.24

The term "hospital" includes all locations of the hospital.

The hospital must have one unified medical record service that has administrative responsibility for all medical records, both inpatient and out patient records. The hospital must create and maintain a medical record for every individual, both inpatient and out patient evaluated or treated in the hospital.

The term "**medical records**" includes at least written documents, computerized electronic information, radiology film and scans, laboratory reports and pathology slides, videos, audio recordings, and other forms of information regarding the condition of a patient.

Survey Procedures §482.24

- Review the organizational structure and policy statements and interview the

TJC Record of Care Chapter Topics

TJC Standards Topics

- MR needs patient's name, address, sex, DOB
- Reason for admission
- Initial diagnosis or condition
- Findings of assessment and reassessments
- Allergies to food and medications
- Conclusion drawn from H&P
- Consult reports
- Patient's responses to care and treatments

TJC Standards Topics

- Emergency treatment given prior to arrival
- Progress notes
- Medications ordered or prescribed
- Plan of care and revisions
- Orders for tests and procedures
- Medication dispensed upon discharge
- Advance directives
- Informed consent

TJC Standards Topics

- Records of communication including telephone calls or emails
- Patient generated information
- ED patients records include
  - Time and means of arrival
  - If patient left AMA
- Conclusions reached at termination of care such as final disposition, conditions, discharge instructions

RC Chapter Topics

- Informed consent
- H&P
- Verbal orders
- Summary list by third outpatient visit deleted
- Discharge information RC.02.04.01
- R&S documentation RC.02.01.05 removed
- Operative or high risk procedures and use of moderate sedation under RC.02.01.03
- Unanticipated outcome (UO) and disclosure

TJC Record of Care Chapter Standards

Overview of RC Standards

- This chapter is a comprehensive set of requirements for those who comply the medical record as to what should be in the chart
- This chapter also contains the documentation requirements for when assessments and reassessments are done
- This includes screening and pre-operative and post-operative documentation
- Includes policies that guide the completion, authentication, retention, and release of medical records

Number One Problematic Standard

- **RC.01.01.01** The hospital maintains complete and accurate medical
- 17 EPS but EP 2, 3, and 14-18 do not apply to hospitals (2 EPs deleted July 1, 2016)
- **Problematic ones:**
  - EP 11 and 19 Regarding date and **TIME** of all entries
  - EP 6 The medical record needs to contain information to justify the patient's care and treatment (medical necessity)

Complete Medical Record RC.01.01.01

- Standard: The hospital must maintain a complete and accurate medical record
- EP1 - The hospital has to define the components of a complete medical record
  - For example, H&P, consult reports, discharge summary, graphics, nurses notes, progress notes, verbal orders signed off, completed within 30 days, etc.
  - CMS to change and require diagnosis and completion of outpatient charts to 7 days

Complete Medical Record

- EP5 to EP8 states that the medical record must contain:
  - EP 4: Information that is unique to the patient that is used for identification
    - Name, address, DOB, medical record number etc.
  - EP 4 was **deleted** July 1, 2016 because it is duplicative if RC.02.01.01 EP 1 and 2

Complete Medical Record

- EP5: Information needed to support the diagnosis and condition
  - Patient admitted for pneumonia with CXR verification, high WBC, decreased pulse ox, chest pain, etc.
- EP 6:Information to justify the patient's care and treatment
  - Important especially with RACs and the two midnight rule
  - Establishing medical necessity is important

Complete Medical Record

- EP5 to EP8 states that the medical record must contain (continued);
  - EP 8 :Information to document the course of care and the results
    - Information in progress notes and nursing notes show course of care
  - Information about the patient that promotes continuity of care
  - AHIMA practice brief has information to help determine what content must be in the MR

AHIMA Maintaining a Legally Sound Record

AHIMA
American Health Information Management Association®

HIM Body of Knowledge
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Update: Maintaining a Legally Sound Health Record—Paper and Electronic

www.ahima.org

The health record is the legal business record for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. The standards may vary based on practice setting, state statutes, and applicable case law. An attorney should review policies related to legal documentation issues to ensure adherence to the most current standards and case law.

HIM professionals should fully understand the principles of maintaining a legally sound health record and the potential ramifications when the record's legal integrity is questioned. This practice brief will review the legal documentation guidelines for entries in and maintenance of the health record—both paper and electronic. Many of the guidelines that originally applied to paper-based health records translate to documentation in electronic health records (EHRs). In addition, new guidelines and functionalities have emerged specific to maintaining legally sound EHRs. It is of the utmost importance to maintain EHRs in a manner that will support a facility's business and legal processes, otherwise duplicate paper processes will need to be maintained.

AHIMA convened an e-HIM® work group to re-evaluate and update the 2002 practice brief

Complete Medical Record

- EP9 - Standardized formats are used to document the care and treatment provided
- EP11 - All entries in the medial record are dated
  - Both TJC and CMS require that all orders be dated and TIMED as in EP 19
- EP12 - Hospital tracks the location of all components of the medical record
  - EKGs, ED triage notes, fetal heart strips, lab test results, etc.

Complete Medical Record

- EP13 - Hospital must assemble or make available a summary in the medical record of all care provided to the patient
  - **DELETED** July 1, 2016 since routine part of operations
  - Summarize care provided in the ED or for a procedure in the discharge summary
  - MM.01.01.01 EP1 requires P&P that physician and staff have information available when participation in medication process (age, sex, diagnosis, allergies, current medications, etc.)

Complete Medical Record

- EP19 - All entries must be TIMED
  - DS or deemed status which means it applies to most hospitals except VA so can get reimbursed for taking care of Medicare and Medicaid patients
  - This is one of the most common problematic standards by both TJC and CMS
  - This includes a date and **time** when verbal orders are signed off
  - Every entry including the order sheet and progress note must be dated and timed

Authenticate Entries RC.01.02.01

- Standard: All entries in the medical record must be authenticated (signed off)
- 5 EPs
- EP1 - Only authorized individuals can make entries in the medical records
  - P&P should identify who can document
  - Examples: RNs, physicians, dieticians, nurses assistants, hospital attorney, pastoral care, etc.
  - AHIMA brief on how to do this for EHR or electronic health record at wwww.ahima.org

AHIMA Attestation & Authorship 10-15-2013

Electronic Signature, Attestation, and Authorship (Updated)

*Editor's note: This update supersedes the November 2009 practice brief "Implementing **Electronic Signatures**."*

Electronic health record (EHR) systems provide the ability to sign entries electronically; however, implementing and using **electronic signatures** (e-signatures) is complex. This practice brief provides insight into the technology used to implement e-signatures, the related health IT standards, the regulatory environment, and recommendations on best practices.

This practice brief provides additional e-signature resources, tools, a glossary, and best practices to assist HIM professionals with EHR implementation and policy development.

While this practice brief addresses an organization's internal approach to determining e-signature policy and procedures, the foundational principles should extend beyond an organization's operations to external health information exchange efforts and participation agreements with HIE partners. As the healthcare industry evolves, an HIE's business plan and supporting functions must include valid, legal, consistent, and agreed-upon e-signature methods of nonrepudiation for use by all participants.

An Evolving Definition of E-Signature

The EHR has changed certain concepts and terms related to signatures. In the past, HIM professionals identified the act of signing an entry as authentication. However, this definition has evolved.

In EHRs, **authentication** is the security process of verifying a user's identity that authorizes the individual to access the system (e.g., the sign-on process). Authentication is important because it assigns responsibility to the user for entries he or she creates, modifies, or views. **Attestation,** on the other hand, is the act of applying an e-signature to the content, showing authorship and legal responsibility for a particular unit of information.[1]

Signatures, like medical records, can be either **analog** (e.g., stored on paper and unable to be read by a computer) or **digital** (e.g., stored on electronic media such as disks that can be read by a computer). The term ***electronic signature*** is frequently used in references and regulations in reference to signatures in a digital format. However, an **electronic signature** is a generic, technology-neutral term for the various ways that an electronic record can be

Electronic Signature Model Policy AHIMA

Electronic Signature, Attestation, and Authorship.

Appendix C: Electronic Signature Model Policy
This template document is not intended for adoption as a substitute for a customized organizational policy of specificity and action steps appropriate to local factors.

Advancing technology and changing surveillance criteria make any technology adaptation an evolution. An applied and reputable approach will balance front-end technology capabilities against back-end administrative controls to measure compliance.

Development of an electronic signature policy is an important aspect of a healthcare organization's legal electronic health record definition. AHIMA recommends legal counsel review the policy during the approval process. If technology limitations preclude implementation of optimal electronic signature approaches, organizations should identify gaps for future technology acquisitions and workflow improvements.

This model policy template recommends important legal and compliance considerations for healthcare organizations' electronic signature policy and procedures. An appropriate organizational policy reflects best practices along with germane international, federal, and state laws and regulations, accreditation standards, payer requirements, documentation requirements for clinical services offered, and technology functionalities.

Term definitions in this document are taken from the glossary in appendix D. They are intended to be used together.

Subject/Title Electronic Signature, Attestation, and Authorship for Medical Record Documentation

Countersignature

- EP2 - Define the types of entries in the medical record made by non-independent practitioners
  - Require countersigning
  - Required by law
- Countersignature requires a professional to review and if appropriate, approve action taken by another

Countersignature

- Include in your P&P whether:
- Supervising physician signs the order written by the resident
  - Two nurses sign to witness wasted narcotics
  - RN needs to co-sign LPN only if your policy requires this
  - Pharmacist cosigns for pharmacy tech if required
- Example: Student CRNA has done pre-anesthesia assessment countersigned by anesthesia provider

Countersignature

- CMS Interpretive Guidelines for Hospitals require that medical staff (MS) R&R identify the types of documents
- or entries non-physicians may complete that require a countersignature by a supervisor or attending MS member
- If credentialed, state scope of practice allows, and hospital P&P allow, PA and NP can order outpatient treatments without a countersignature of physician

Authenticate Entries

- EP3 - Need to be able to determine the author of each entry in the medical record
  - Sign each entry with name in accordance with P&P - full name or first initial and last name and some hospitals require a number after the name
- Nurse may use initials on the medication record with legend below
  - Hospitals may have physician also write down an identification number to make sure you can tell who wrote the order

AHIMA Documentation Standards

1. ***Signature***

   Entries are typically authenticated by a signature. At a minimum the signature should include the first initial, last name and title/credential. A facility can choose a more stringent standard requiring the author's full name with title/credential to assist in proper identification of the writer. If there are two people with same first initial and last name both must use their full signatures (and/or middle initial if applicable).
   Facility policies should define the acceptable format for signatures in the medical record.

Authenticate Entries

- EP4 - Entries in the MR need to be authenticated by the author
  - Information introduced in the MR by transcription or dictation must be signed off by the author
  - Physician or LIP must sign off on a verbal order with date and time
  - A physician can affix an **electronic signature,** if electronic record, after dictating a H&P, operative report, or consult report
    - The electronic signature must be date stamped
    - Sign name and date and time if paper record
    - Verbal orders need to be signed off and dated and timed

Signature Stamp

- EP5 - The physician or person identified by the signature stamp or method of electronic signature is the only one who uses it
  - Physicians and others, should sign a form to this effect and create a list to cross reference to the individual
  - Include in P&P along with penalties for misuse
  - Many hospitals **no** longer allow signature stamps since Medicare and many other insurers and fiscal intermediaries will not pay if order is written and a signature stamp is used instead of signing the order

JOURNAL OF AHIMA

A Complete Ban on Signature Stamps

Oct 22, 2008 11:48 am | posted by Kevin Heubusch | Coding & reimbursement & Compliance & HIM operations

UPDATE: CMS has since released new clarification stating that stamps are not prohibited under the Conditions of Participation, but that some payers may not accept them.

The Centers for Medicare and Medicaid Services no longer accepts signature stamps on any record. CMS attempted to clarify the scope of the ban this summer, but the message may not have percolated to all corners of the industry yet.

In July CMS stated that "stamped signatures are not acceptable on any medical record." The prohibition applies to all providers and suppliers. Medicare will only accept "handwritten, electronic signatures or facsimiles of original written or electronic signatures."

In spring CMS published a ban on signature stamps focused narrowly on the certification of terminal illness for hospice. The subsequent July notice explicitly included all medical records.

In the upcoming November-December *Journal,* Gloryanne Bryant, RHIA, CCS, recommends that HIM professionals ensure compliance with the ban by participating in documentation checks in areas that have commonly used signature

CMS Signature Guidelines

- April 16, 2010 CMS issues new signature guidelines and says no rubber stamps
- CMS issued a change request updating the Program Integrity Manual on signature guidelines for medical review purposes
- Requires legible identifier in form of handwritten or electronic signature
- Third exception is cases where national coverage determination (NCD), local coverage determination (LCD) or if CMS manual has specific guidelines takes precedence over above

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 327	Date: March 16, 2010
	Change Request 6698

SUBJECT: Signature Guidelines for Medical Review Purposes

I. SUMMARY OF CHANGES: Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare administrative contractors, the comprehensive error rate testing contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language of the Program Integrity Manual required a legible identifier in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

EFFECTIVE DATE: MARCH 1, 2010
IMPLEMENTATION DATE: April 16, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.4.1.1/Documentation Specifications for Areas Selected for Prepayment or

contractors, or ACs), Medicare administrative contractors (MACs), the comprehensive error rate testing (CERT) contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language in the PIM required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

B. Policy: Clarifies and updates various sections of the Program Integrity Manual.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6698.1	All signature requirements in this CR are effective retroactively for CERT for the November 2010 report period.										CERT
6698.2	All signature requirements for ACs, MACs, PSCs and ZPICs are applicable for reviews conducted on or after 30 days after the issuance of this CR.	x	x	x	x	x					CERT, PSC, ZPIC
6698.3	For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.	x	x	x	x	x					CERT, PSC, ZPIC
6698.4	Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, (e.g. signatures on plans of care must be signed prior to services being rendered), those signature requirements take precedence.	x	x	x	x	x					CERT, PSC, ZPIC
6698.5	For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the	x	x	x	x	x					CERT, PSC,

Exception Physician with a Disability

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8219.pdf

Use of a Rubber Stamp for Signature

Provider Types Affected

This MLN Matters® Article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME) MACs) for services provided to Medicare beneficiaries.

What You Need to Know

For medical review purposes, the Centers for Medicare & Medicaid Services (CMS) requires that services ordered/provided be authenticated by a handwritten or electronic signature. With few exceptions, stamped signatures are not acceptable as described in Chapter/Section 3.3.2.4 of the "Medicare Program Integrity Manual." Change Request (CR) 8219 adds another exception to that manual. Under the added exception, CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that

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Centers for Medicare & Medicaid Services

Medicare Learning Network®
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www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Complying with Medicare Signature Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements and provides information on the documentation needed to support a claim submitted to Medicare for medical services and supplies.

Please Note:
The information in this publication applies only to the Fee-For-Service Program (also known as Original Medicare).

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) improper payment rate, as required by the Improper Payments Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Improvement Act of 2012. CERT randomly selects a statistically-valid, stratified random sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates a national Medicare FFS paid claims improper payment rate and improper payment rates by claim type. The results of these reviews are reported annually.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare Trust Fund while protecting patients from medically unnecessary services or supplies. Table 1 provides answers to questions about Medicare signature requirements.

Table 1. Medicare Signature Requirements Questions & Answers

Question	Answer
What is required for a valid signature?	For a signature to be valid, the following criteria must be met: • Services that are provided or ordered must be authenticated by the ordering practitioner; • Signatures are handwritten, electronic, or stamped (stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of an inability to sign due to a disability); and • Signatures are legible. Reference: CMS "Medicare Program Integrity Manual" (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf on the CMS website.
What should I do if I have not signed an order or medical record?	You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record. Your contractor may offer specific guidance regarding addenda to medical records. If an order for tests is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating "Ordering Lab" is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment. Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.3.2.4.
What if the physician signs the order or progress note, but the signature is not legible?	You may submit a signature log or attestation statement to support the identity of the illegible signature. If the original record contains a printed signature below the illegible signature, this may be accepted. Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.3.2.4.A.
What is a signature log?	A signature log is a typed listing of the provider(s) identifying their name with a corresponding handwritten signature. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation. Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.3.2.4.B

CMS Signature Stamp Exceptions

Medicare Program Integrity Manual
Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

Table of Contents

(Rev. 657, 06-17-16)

Transmittals for Chapter 3

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

CMS Signature Requirements

3.3.2.4 - Signature Requirements
(Rev. 604, Issued: 07-24-15, Effective: 08-25-15, Implementation: 08-25-15)

This section is applicable for MACs, CERT, SMRC, and ZPICs. This section does not apply to Recovery Auditors.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and the CMS' instructions regarding conditions of payment related to signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

Handwritten Signature CMS Program Integrity Manual

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, MACs and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

Document Timely RC.01.03.01

- Standard: The hospital documents timely in the medical record
- EP1 - The hospital has a written P&P to require entries in the medical record be timely
  - Best to document ASAP while information is still fresh in your memory
  - Important when introducing MR into court room as Federal Rules of Evidence require that entries be made at or near the time the care was rendered
  - References PC01.02.03 EP1 where hospitals defines time frames to do assessments and reassessments

Document Timely

- Important to communicate information to others
  - During hand offs
  - When nurse not available at the time physician or other healthcare provider is visiting patient
- Entries need to be timely for continuity of care and to prevent medical errors from occurring
  - Nurse told by mother she removed ticks from both boys, but didn’t document until after first child died

Document Timely

- EP2 - The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after discharge
  - Hospitals may want to consider having **discharge summary** dictated when patient discharged and then should document that it got it into the hands of the PCP before the first visit
  - This is the current CMS requirement unless patient is discharged without an appointment then it is 7 days and also in the CMS discharge planning worksheet
  - In proposed CMS discharge planning standards the discharge summary and discharge instructions must be in the hands of the LP or PCP within **48 hours**

Final CMS Discharge Planning Worksheet

Centers for Medicare & Medicaid Services

HOSPITAL PATIENT SAFETY INITIATIVE (PSI)

FY 2014 DRAFT RISK EVALUATION TOOL

Discharge Planning

Name of State Agency:

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of interviews, observation, review of the hospital's discharge planning program documentation including policies and procedures, and review of medical records.

The interviews should be performed with the most appropriate hospital staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Please submit completed form by clicking the Submit Form button at the top of the page *or by attaching the form to an email to* Hospital_DC@AcumenLLC.com.

Section 1 Hospital Characteristics

1. Hospital name:
2. CMS Certification Number (CCN):
3. Date of site visit:

/ / to / /

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4	Patient/Record #5
4.18f Referrals, if applicable, to specialized ambulatory services, e.g. PT, OT, HHA, hospice, mental health, etc.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
4.18g Referrals, if applicable, to community-based resources other than health services, e.g. Depts. of Aging, elder services, transportation services, etc.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
4.18h Arranging essential durable medical equipment, e.g. oxygen, wheel chair, walker, hospital bed, commode, etc., if applicable.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
4.18i Sending necessary medical information to providers the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first. NOTE: Only use N/A if the patient was transferred to a post-acute care facility or if the patient has a scheduled follow-up appointment with the attending physician.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A

CMS Discharge Planning Worksheet

- The CMS 2014 final discharge planning worksheet was changed in the final copy
  - Was discharge summary sent **before first post-discharge appointment** or within 7 days of discharge?
  - Was follow up appointment scheduled?
- Now says send necessary medical record information to providers the patient was referred prior to the first post-discharge appointment or 7 days, whichever comes first (820)

CMS Proposed Discharge Planning

FEDERAL REGISTER

Vol. 80 Tuesday,
No. 212 November 3, 2015

www.gpo.gov/fdsys/pkg/FR-2015-11-03/pdf/2015-27840.pdf

Part IV

Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Parts 482, 484, 485
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule

Document Timely

- EP3 - Hospital implements its P&P requiring staff to timely enter information in the MR
  - PC.01.02.03 EP1 requires hospital to specify time frame for doing initial patient assessment such as 2 or 6 hours
  - Many hospitals have shortened the time frame to reduce the LOS
  - Can’t be longer than 24 hours

Document Timely

- EP4 - The H&P, including updates, needs to be documented in the MR within 24 hours after inpatient admission and before surgery or a procedure requiring anesthesia (DS)
- CMS requires:
  - H&P be on chart within 24 hours of admission
  - H&P be no older than 30 days and updated prior to surgery
- Make sure H&P on chart before patient goes to surgery unless emergency and audit this

MR Audits RC.01.04.01

- Standard: Hospital audits its medical records
- All hospitals have audit tools that are used to determine compliance with MR standards, guidelines and laws
- Some tools include concurrent monitoring to assure documentation is complete and timely at the present time as opposed to audits done after the patient is discharged

Hospital Audit Tool

OPERATIVE/INVASIVE QA Audit Tools

Surgery Date: **Surgeon:** **MR#:**
Procedure:

Indicators:	YES	NO	NA
1. Clinical Indication met			
2. Consent signed, dated and present in the medical record.			
2a. If No: Name of RN/Unit and forward copy to Director			
3. Time Out procedure and site marking by provider if applicable.			
If no: Name of RN/Unit and forward copy to Director			
4. Pre and Post Op diagnosis match			
5. Immediate post-op note by surgeon present			
5a. Note Dated and Timed by provider			
6. Documented H & P <30 days 6a. H & P updated on day of surgery or completed on day of surgery			
7. Intra-operative complication of the procedure? (Physician review required)			
8. Amount of blood loss (Physician review if > 800 cc)			
9. Unplanned return to OR 9a. Forward info to Risk			
10. Unplanned admission to ICU/CCU			

AQI Audit/PI Tools Anesthesia

Anesthesia Quality Improvement PACU Discharge

Case Info			
Date		Anesthesia type	
MR #		Provider ID	
ASA Class		CRNA ID	
		Additional provider	

www.aqihq.org/qualitymeasurementtools.aspx

	Yes	No
Patient is awake and able to contribute to assessment		

Patient Physical Exam:	Yes	No
Mental Status at baseline (Y/N)		
Vital Signs at baseline (Y/N)		
Airway patency at baseline (Y/N)		

Pain Score (10-point VAS scale):		
on PACU admission		
Highest pain score		
Pain score at time of assessment		

Nausea or vomiting requiring treatment		

Any occurrence of vomiting		

Did the patient experience an unexpected event during perioperative care?	Yes	No		Yes	No
Unplanned ICU admission			Anaphylaxis		
Unplanned hospital admission			Other medication reaction		
Intraoperative awareness			Delayed emergence		
Epidural hematoma			Respiratory arrest		
Peripheral neurologic deficit			Reintubation		
Corneal abrasion			Dental trauma		
Agitation requiring treatment			Aspiration		
Seizure			Cardiac arrest		

Anesthesia Quality Improvement Intra-Operative

Case Info		Anesthesia type	
Date		Provider ID	
MR #		CRNA ID	
ASA Class		Additional provider	

NO UNTOWARD EVENT		Death (Excludes ASA 6 patients presenting for harvesting)			
Case Cancelled		Unplanned ICU Admission		Operation on incorrect site	
Case Delayed		Unplanned admission of outpatient		Operation on incorrect patient	
Incorrect procedure					
Pulmonary Edema		Cardiac Arrest		Bronchospasm req treatment	
Hypotension requiring unanticipated therapy with a continuous infusion or pressor agents		New PVC's, bradycardia, atrial fibrillation, or other dysrhythmias requiring unanticipated therapy		Myocardial ischemia, indicated by ST segment changes or echocardiography	
Unanticipated difficult airway		Unplanned reintubation		Aspiration	
Inability to secure an airway		Unplanned respiratory arrest		Laryngospasm	
Anaphylaxis		Transfusion Reaction		Delayed emergence	
Other unanticipated adverse reaction to medication		Use of sedation/narcotic reversal agents		Inability to reverse neuromuscular blockade	
Malignant Hyperthermia		Medication error			
High spinal		Failed regional anesthetic		Unintended dural puncture	
Vascular access complication - vessel injury		Vascular access complication - pneumothorax		Local anesthesia systemic toxicity	

AHIMA List of P&P

Audit Schedule**

Audit and Monitoring System**

- Audit/Monitoring Schedule
- Admission/Readmission Audit
- Concurrent Audit
- Discharge Audit
- Specialized Audits (examples)
- Change in Condition
- MDS
- Nursing Assistant Flow Sheet
- Psychotropic Drug Documentation
- Pressure Sore
- Restrictive Device/Restraint
- Therapy

Medical Record Audits

- EP1 - Hospital conducts an ongoing review of MRs at the point of care
- Audit must be based on the following indicators:
  - Presence
  - Timeliness
  - Legibility (if handwritten or printed)
  - Accuracy
  - Authentication
  - Completeness of data and information

MEDICAL RECORD AUDIT TOOL

DIRECTIONS FOR COMPLETION

This document is intended for use as a tool for a review of medical record documentation compliance with Joint Commission standards. Results from this audit may be used to identify systems or process deficiencies within the hospital, and can be used to prioritize improvement opportunities and facilitate staff education and training.

This tool should be used when completing a comprehensive open/closed record review. The questions are related to specific Joint Commission standards and Elements of Performance (EP), and each standard/EP can be referenced at the end of each question. Refer to the Joint Commission manual if further clarification regarding the intent of the standard is needed.

When completing this audit, there are two different response scales that are used:

☐ N/A	☐ Yes	☐ No

- This scale applies to questions that indicate either the presence, or a lack thereof, of a specific documentation or process requirement within the medical record. Its use is self-explanatory.

- If the standard does not apply, check the "N/A" box.

Any pertinent comments regarding each standard may be recorded in the "Comments" section beneath each question. This field should be used to track key information to be used for staff education (including staff names to allow follow-up) or other performance improvement. Refer to the Medical Record Audit "Cheat Sheet" for guidance on where to locate specific elements for this audit within the medical record.

Name(s) of Auditor(s): Date Audit Completed:

PROVISION OF CARE Standards Review

1.	If the patient was transferred (discharge status code 02 on face sheet), was it because the hospital does not perform the care, treatment, or service the patient required? (PC.1.10 #5)		☐ N/A	☐ Yes	☐ No
	Comments: _____				
2.	Is the completed H&P dated 30 days prior to or within 24 hours of admission? (PC.2.120 #5)		☐ N/A	☐ Yes	☐ No
	Admission time and date:_____ H&P time and date:_____ Comments: _____				
3.	If the patient is a surgical patient, was the H&P updated within 7 days of surgery? (PC.2.120 #7)		☐ N/A	☐ Yes	☐ No
	Comments: _____				
4.	Does the chart have a completed initial assessment? (Health Assessment I & II, N/A for OPS patients) (PC.2.130 #1)		☐ N/A	☐ Yes	☐ No
	Comments: _____				
5.	Has the patient's condition been updated since the initial assessment? (PC.2.120 #7)		☐ N/A	☐ Yes	☐ No
	Comments: (numerator & denominator)_____				
6.	When pain is identified, was the patient treated by the hospital or referred for treatment? (PC.2.150 #1)		☐ N/A	☐ Yes	☐ No
	Comments: _____				

MR Audits

- MS.05.01.03 EP3 requires the MS to participate in auditing to determine that the MR are accurate, timely and legible
  - Common problematic standard is every entry needs to be timed
  - Also legibility is a problem
- Medication management tracer will ask staff about P&P if entry is illegible

MR Delinquency Rate

- EP3 - Hospital measures its medical record delinquency rate at regular intervals, but no less than every three months
- **DELETED** July 1, 2016 since routine part of operations
- What is your definition of legible such as if 2 individuals are unable to read
- Scribes can be used but need to have them sign and date and time with physician's immediate review and signature (Date and time and see TJC scribe FAQ)

Human Resources (CAMH / Hospitals)

Use of Unlicensed Persons Acting as Scribes

Revised | July 12, 2012

Q. What is a scribe and how are they used?

A. A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities.

Scribes also assist the practitioners listed above in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding.
Scribes are used most frequently, but not exclusively, in emergency departments where they accompany the physician or practitioner and record information into the medical record, with the goal of allowing the physician or practitioner to spend more time with the patient and have accurate documentation. Scribes are sometimes used in other areas of the hospital or ambulatory facility. They can be employed by the healthcare organization, the physician or practitioner or be a contracted service.

Q. Do the Joint Commission standards allow organizations to utilize scribes?

A. The Joint Commission does not endorse nor prohibit the use of scribes. However, if your organization chooses to allow the use of scribes the surveyors will expect to see:

Compliance with all of the Human Resources, Information Management, Leadership (contracted services standard)and Rights and Responsibilities of the Individual standards including but not limited to:

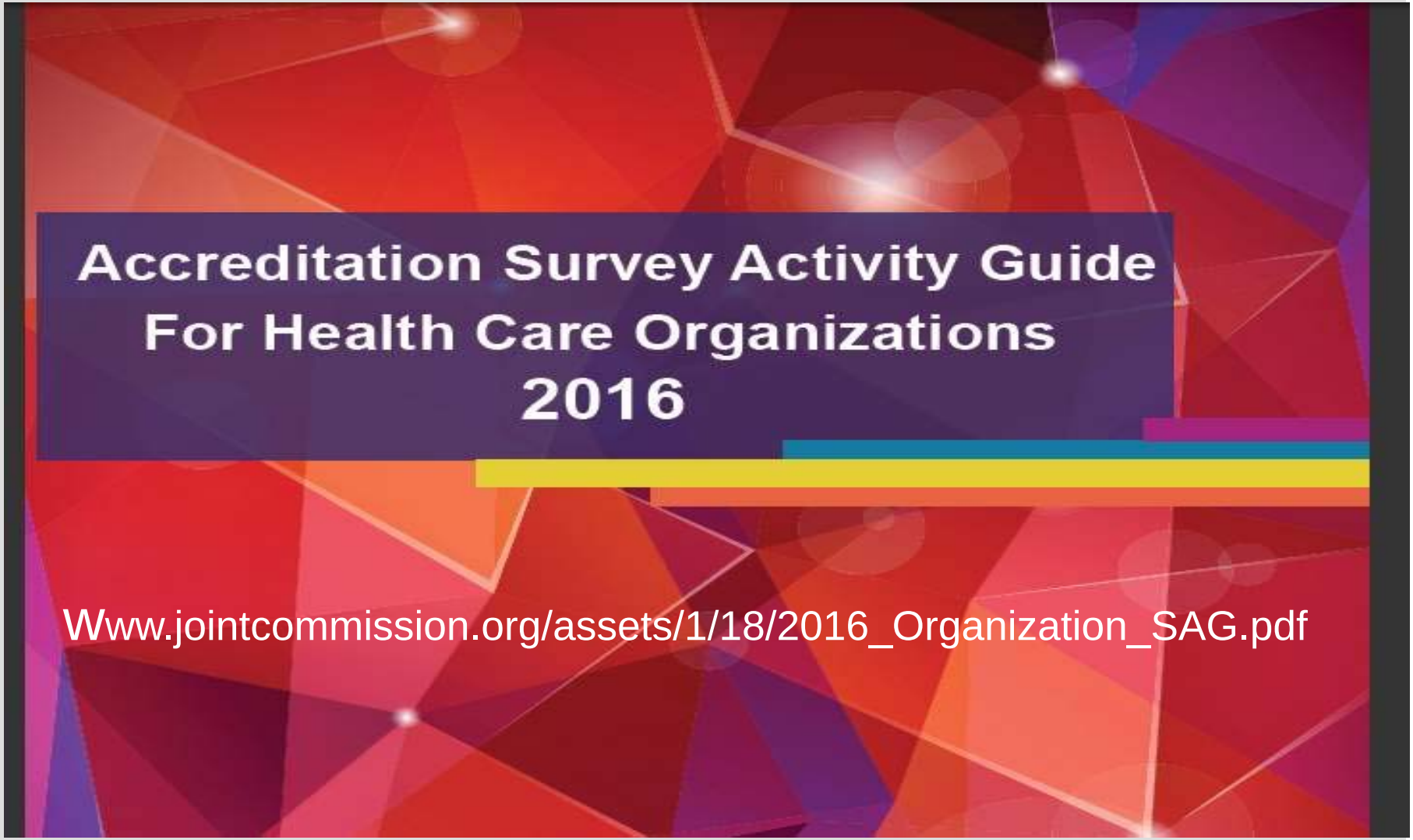
- A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities (HR.01.02.01, HR.01.02.05)
- Orientation and training specific to the organization and role (HR.01.04.01, HR.01.05.03)
- Competency assessment and performance evaluations (HR.01.06.01, HR.01.07.01)
- If the scribe is employed by the physician all non-employee HR standards also apply (HR.01.02.05 EP 7, HR.01.07.01 EP 5)

MR Statistic Form

- EP4 - The medical record delinquency rate averaged from the last four quarterly measurements is 50% or less of the average monthly discharge (AMD) rate
- **DELETED** since duplication of RC.01.03.01 EP2
- Each individual quarterly measurement is no greater than 50% of the AMD rate
- MR Statistics Form[1] can be used to calculate the quarterly and annual average medical record delinquency rate and form

1 http://www.jointcommission.org/Hospital_Medical_Record_Statistics_Form/

MR Statistics Form Now in Survey Guide



Hospital Medical Record Statistics Form
(Determines compliance with RC.01.04.01 EP 4)

Organization ID:_____ City/State_____	Box #
Average Monthly Discharge Rate (AMD): Total number of inpatient discharges in the 12 months prior to survey ÷ 12. This number represents all inpatient records, and can include other records if they are observation visits, ambulatory surgery visits, endoscopy visits, cardiac catheterization visits, and Emergency Department visits. No other type of ambulatory or outpatient encounter may be included. Place this number in **Box #1.**	1
Medical Record Delinquency Timeframe: Place the number of days within which a medical record must be completed, as specified within the Medical Staff rules and regulations, in **Box #2**. This value may not exceed 30 days. If the Medical Staff has not defined this value, or if the defined number exceeds 30, place the number 30 in **Box #2**.	2
Monthly Delinquency Totals	
Calculate the total number of medical records which are delinquent (not completed within the number of days specified in Box #2), on the last day of the month immediately preceding the survey. This is a cumulative number and includes all records still delinquent on the last day of that month, for any reason. This number represents all inpatient records, and **must** include other records such as observation visits, ambulatory surgery visits, endoscopy visits, cardiac catheterization visits, and Emergency Department visits, **if they were included in Box #1.** No other type of ambulatory or outpatient encounter may be included. Place this number in **Box #3.** **Or, in other words: Most recent month →**	3
• Use instructions for Box #3, for the mo. preceding the one in Box #3. This is the month of _____ Place # in **Box #4.** →	4
• Use instructions for Box #3, for the mo. preceding the one in Box #4. This is the month of _____ Place # in **Box #5.** →	5
• Use instructions for Box #3, for the mo. preceding the one in Box #5. This is the month of _____ Place # in **Box #6.** →	6
• Use instructions for Box #3, for the mo. preceding the one in Box #6. This is the month of _____ Place # in **Box #7.** →	7
• Use instructions for Box #3, for the mo. preceding the one in Box #7. This is the month of _____ Place # in **Box #8** →	8
• Use instructions for Box #3, for the mo. preceding the one in Box #8 This is the month of _____ Place # in **Box #9** →	9
• Use instructions for Box #3, for the mo. preceding the one in Box #9. This is the month of _____ Place # in **Box #10.** →	10
• Use instructions for Box #3, for the mo. preceding the one in Box #10. This is the month of _____ Place # in **Box #11.** →	11
• Use instructions for Box #3, for the mo. preceding the one in Box #11. This is the month of _____ Place # in **Box #12** →	12
• Use instructions for Box #3, for the mo. preceding the one in Box #12. This is the month of _____ Place # in **Box #13** →	13
• Use instructions for Box #3, for the mo. preceding the one in Box #13. This is the month of _____ Place # in **Box #14** →	14

Quarterly Numerator Averages				Total Numerator Avg.
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**
Add the numbers in boxes 3, 4,& 5, ÷ 3, and	Add the numbers in boxes 6, 7 & 8, ÷ 3, and	Add the numbers in boxes 9, 10 & 11,÷ 3, and place	Add the numbers in boxes 12, 13 & 14 ÷ 3, and place	Add the numbers in boxes 15, 16, 17 & 18, ÷ 4, and

MR Retention RC.01.05.01

- Standard: The hospital retains its MR as determined by P&P
- EP1 - The MR retention period is determined by its use and hospital P&P and is in accordance with law and regulation
- CMS hospital CoP retention period is 5 years for hospitals and 6 years for CAH
  - There is a 10 year retention period required by CMS on blood and tissue records and for Medicare Managed Care
  - HIPAA is 6 years

MR Retention RC.01.05.01

- AHIMA has a practice brief and chart on federal retention periods[1]
- Question 14 on the IRS Form 990 asks nonprofit hospitals if they have a policy on retention and destruction
- Establish a formal process for maintaining, retaining and destroying records

[1]www.ahima.org

Retention & Destruction Medical Records 10/15/2013

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Retention and Destruction of Health Information

Editor's note: This update ***supersedes*** *the August 2011 practice brief "Retention and Destruction of Health Information."*

Health information management professionals traditionally have performed retention and destruction functions using all media, including paper, images, optical disk, microfilm, DVD, and CD-ROM. The warehouses or resources from which to retrieve, store, and maintain data and information include, but are not limited to, application-specific databases, diagnostic biomedical devices, master patient indexes, and patient medical records and health information. To ensure the availability of timely, relevant data and information for patient care purposes; to meet federal, state, and local legal requirements; and to reduce the risk of legal discovery, organizations must establish appropriate retention and destruction schedules. This practice brief provides guidance on record retention standards and destruction of health information for all healthcare settings.

Records Retention

The life cycle of records management begins when information is created and ends when the information is destroyed. The picture below provides a simple reflection of the entire records retention process. The goal for organizations is to manage each step in the record life cycle to ensure record availability. The creation of information is easy to establish, and most organizations do not have concerns when creating or using information. However, when maintaining information, various issues may arise.

Sample Certificate of Destruction

Facility Name

The information described below was destroyed in the normal course of business pursuant to a proper retention schedule and destruction policies and procedures.

Date of destruction:_____

Description of records or record series disposed of:

_____

_____

Inclusive dates covered:_____

http://bok.ahima.org/doc?oid=105016#.V5WUorTfPb0

Method of destruction:

( ) Burning ( ) Shredding ( ) Pulping ( ) Demagnetizing ( ) Overwriting ( ) Pulverizing ( )

Other:_____

Records destroyed by:_____

[LOGIN]

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Retention and Destruction of Health Information (2013 update)

http://bok.ahima.org/PB/RetentionDestruction#.V5WVWLTfPb0

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Appendix A: Federal Record Retention Requirements

Type of Documentation	Retention Period	Citation/Reference
Abortions and related medical services documentation	Maintain for three years.	42 CFR 50.309
Ambulatory surgical services	Retention periods are not specified	42 CFR 416.47
Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services	As determined by the respective state statute, or the statute of limitations in the state. In the absence of a state statute, five years after the date of discharge; or in the case of a minor, three years after the patient becomes of age under the state law or five years after the date of discharge, whichever is longer.	42 CFR 485.721(d)
Clinics, rural health	Six years from date of last entry and longer if required by state statute.	42 CFR 491.10 (c)
Competitive medical plans (See HMOs, competitive medical plans, healthcare prepayment plans)		
Comprehensive outpatient rehabilitation facilities (CORFs)	Five years after patient discharge.	42 CFR 485.60 (c)
Critical access hospitals (CAHs)	Six years from date of last entry, and longer if required by state statute, or if the records may be needed in any pending proceeding.	42 CFR 485.628 (c)
Department of Veterans Affairs		

Table 1 -- AHIMA's Recommended Retention Standards

Health Information	Recommended Retention Period
Diagnostic images (such as x-ray film)	5 years
Disease index	10 years
Fetal heart monitor records	10 years after the infant reaches the age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after the most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgicial procedures	Permanently

Recommendations

- Each healthcare provider should ensure that patient health information is available to meet

Have A Destruction Policy

Destruction of Patient Health Information

Destruction of patient health information by an organization or provider must be carried out in accordance with federal and state law pursuant to a proper written retention schedule and destruction policy approved by appropriate organizational parties. Records involved in any open investigation, audit, or litigation must not be destroyed until the litigation case has been closed.

As with record retention, there is no single standard destruction requirement. Some states require organizations create an abstract of the destroyed patient information, notify patients when destroying patient information, or specify the method of destruction used to render the information unreadable. Organizations should reassess the method of destruction annually based on current technology, accepted practices, and availability of timely and cost-effective destruction services.

In the absence of any state law to the contrary, organizations must ensure paper and electronic records are destroyed with a method that provides for no possibility of reconstruction of information.

Examples of destruction methods are provided below:

- Paper record methods of destruction include burning, shredding, pulping, and pulverizing.
- Microfilm or microfiche methods of destruction include recycling and pulverizing.
- Laser discs used in write once-read many document-imaging applications are destroyed by pulverizing.
- Computerized data are destroyed by magnetic degaussing.
- DVDs are destroyed by shredding or cutting.
- Magnetic tapes are destroyed by demagnetizing.

Organizations must maintain documentation of the destruction of health records permanently and include the following (see appendix D for a sample form):

- Date of destruction
- Method of destruction
- Description of the disposed records
- Inclusive dates
- A statement that the records were destroyed in the normal course of business
- The signatures of the individuals supervising and witnessing the destruction

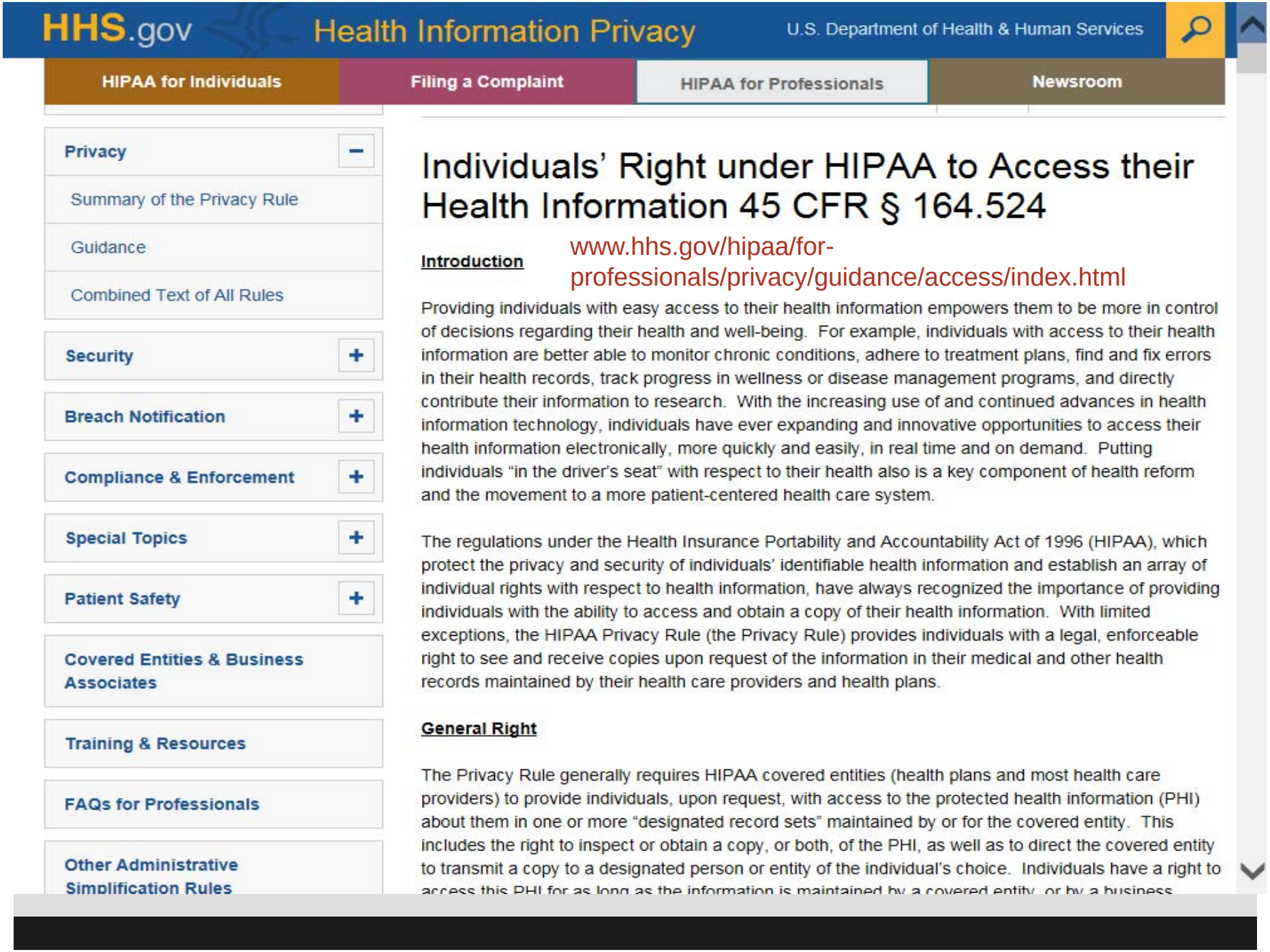
Release of Original MR RC.01.05.01

- EP8 - Original MRs are not released unless the hospital is responding to law and regulation
  - Usually a copy of the medical record is released pursuant to a HIPAA authorization form
  - Usually the original MR should not be removed from the hospital
  - Occasionally, a court order may require the original records be brought to court
    - Ask if a certified copy of the original is acceptable
  - 2 important documents in 2016 from OCR

OCR Rights of Individual Patients

- OCR has document on patient rights under HIPAA to access their health information
- Patients have a right of access to their information
- Includes right to inspect medical records
- Can allow email to make requests or fax
- Would need to verify the identity of the patient
- Can not require person to come in person to request records
- Can’t require patient to mail you the authorization

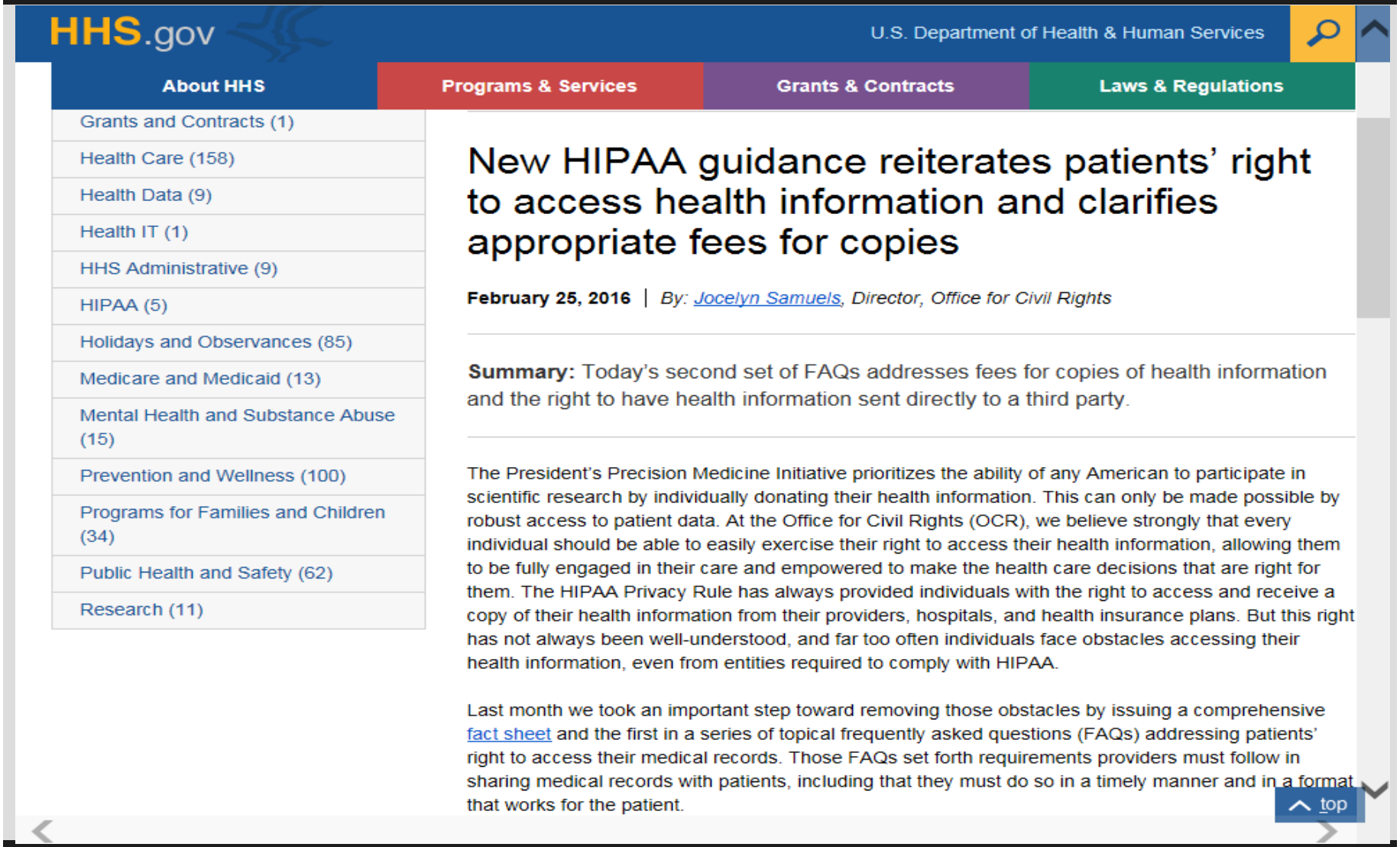
OCR Resources


HHS.gov
Health Information Privacy
U.S. Department of Health & Human Services
HIPAA for Individuals
Filing a Complaint
HIPAA for Professionals
Newsroom
Privacy
Summary of the Privacy Rule
Guidance
Combined Text of All Rules
Security
Breach Notification
Compliance & Enforcement
Special Topics
Patient Safety
Covered Entities & Business Associates
Training & Resources
FAQs for Professionals
Other Administrative Simplification Rules
Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524
www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html
Introduction
Providing individuals with easy access to their health information empowers them to be more in control of decisions regarding their health and well-being. For example, individuals with access to their health information are better able to monitor chronic conditions, adhere to treatment plans, find and fix errors in their health records, track progress in wellness or disease management programs, and directly contribute their information to research. With the increasing use of and continued advances in health information technology, individuals have ever expanding and innovative opportunities to access their health information electronically, more quickly and easily, in real time and on demand. Putting individuals "in the driver's seat" with respect to their health also is a key component of health reform and the movement to a more patient-centered health care system.
The regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protect the privacy and security of individuals' identifiable health information and establish an array of individual rights with respect to health information, have always recognized the importance of providing individuals with the ability to access and obtain a copy of their health information. With limited exceptions, the HIPAA Privacy Rule (the Privacy Rule) provides individuals with a legal, enforceable right to see and receive copies upon request of the information in their medical and other health records maintained by their health care providers and health plans.
General Right
The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. Individuals have a right to

OCR Rights of Individual Patients

- Patient can request a paper or electronic copy
- Must send to patient within 30 days of request
- A 30 day extension is available if archived offsite and not readily accessible
- Can charge for records but no retrieval fee
- Discusses the reasons when a hospital may deny the request
- Can request copies of x-rays
- Can’t refuse to give copies because hospital bill not paid

Second FAQ Feb 2016



HHS.gov

U.S. Department of Health & Human Services

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- Grants and Contracts (1)
- Health Care (158)
- Health Data (9)
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- Holidays and Observances (85)
- Medicare and Medicaid (13)
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New HIPAA guidance reiterates patients' right to access health information and clarifies appropriate fees for copies

February 25, 2016 | *By: Jocelyn Samuels, Director, Office for Civil Rights*

Summary: Today's second set of FAQs addresses fees for copies of health information and the right to have health information sent directly to a third party.

The President's Precision Medicine Initiative prioritizes the ability of any American to participate in scientific research by individually donating their health information. This can only be made possible by robust access to patient data. At the Office for Civil Rights (OCR), we believe strongly that every individual should be able to easily exercise their right to access their health information, allowing them to be fully engaged in their care and empowered to make the health care decisions that are right for them. The HIPAA Privacy Rule has always provided individuals with the right to access and receive a copy of their health information from their providers, hospitals, and health insurance plans. But this right has not always been well-understood, and far too often individuals face obstacles accessing their health information, even from entities required to comply with HIPAA.

Last month we took an important step toward removing those obstacles by issuing a comprehensive fact sheet and the first in a series of topical frequently asked questions (FAQs) addressing patients' right to access their medical records. Those FAQs set forth requirements providers must follow in sharing medical records with patients, including that they must do so in a timely manner and in a format that works for the patient.

top

MR Must Contain RC.02.01.01

- Standard: The medical record must contain information that reflects the patient's care and treatment
  - Amended July 2, 2014 EP 2
- EP1 - The medical record must contain the following demographic information
  - Patient's name, address, date of birth, and name of any legally authorized representative
  - Sex
  - Legal status of patient receiving behavioral health (incompetent with guardian or proxy, involuntary admission etc.)

MR Must Contain RC.02.01.01

- The patient's communication needs, including preferred language for discussing health care
  - See also PC.02.01.21 EP1 The hospital effectively communicates with patient when providing care and treatment
  - Hospital identifies the patients' oral and written communication needs, including their preferred language such as glasses, hearing aids, Interpreter, white boards, TDD, caption TV,
- If patient is minor or incapacitated or has an advocate then document in the medical record

Changes MR Must Contain

- Standard to improve patient centered communication
- Qualifications for language interpreters and translators will be met through proficiency, assessment, education, training, and experience
- Hospitals need to determine the patient's oral and written communication needs and their preferred language for discussing health care under PC standard
- Hospital will communicate with patients in a manner that meets their communication needs

Changes MR Must Contain

- Collecting race and ethnicity data under RC.02.01.01 EP1 and moved to EP 28
- Collecting language data under RC.02.01.01 EP1
- The patient's communication needs, including preferred language for discussing health care
  - If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the MR

MR Must Contain

- EP2 MR must contain the following clinical information (Revised July 2, 2014)
  - Reason for admission or treatment
  - Initial diagnosis, diagnostic impression, or condition
  - All orders
    - CMS hospital CoP problematic standard
    - Make sure all orders for drugs and biologicals, rehab, radiology, and respiratory orders are recorded in the order sheet

MR Must Contain

- Finding of assessments and reassessments
  - PC.01.02.01, EP1 - Hospital defines in writing the scope and content of screening, assessment, and reassessment information it collects
  - PC.03.01.03, EPs1 - Pre-sedation or pre-anesthesia assessment is done before surgery or a high risk procedure
  - CMS requires 48 hours before first drug is given to induce anesthesia
  - PC.03.01.03, EP 8 - Patient is reevaluated immediately before moderate or deep sedation

MR Must Contain

- Allergies to food or medications
- Conclusions or impressions from the patient's medical H&P examination
- Diagnoses or conditions established during the patient's course of care including complications and hospital acquired infections
  - Often called healthcare associated infections or HAIs
- Consult reports

MR Must Contain

- Observations and patient response to care
- All orders
- Emergency care or treatment
- Progress notes
- Any medications ordered or administered along with dose, route and strength

MR Must Contain

- Access site for medication, administration devices used, and rate of administration
- Adverse drug reactions (ADR)
- Treatment goals, plan of care, and revisions to the plan of care
  - PC.01.03.01, EP1 and 23 that requires the hospital to plan the patient's care based on their needs and assessment and has a result of diagnostic testing and revise as necessary
  - Plan of care common problematic standard

MR Must Contain

- Results for diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge
- Discharge diagnosis
- Discharge plan and discharge planning evaluation

MR Must Contain

- EP4 - MR must contain
  - **Advance directive** (AD) and RI.01.05.01, EP 11, requires that staff involved in patient's care are aware of whether or not the patient has an AD
  - **Informed consent** as required by hospital P&P and in accordance with RI.03.01 EP 11
    - Requires a discussion of about reasonable alternatives to the patient's proposed care or treatment
    - Requires a discussion of the risks, benefits, and side effects related to the alternatives, and the risks related to not receiving the proposed care or treatment

MR Must Contain

- EP4 - MR must contain (continued)
  - Patient generated information
  - Records of communication with the patient including telephone calls or e-mail
    - Discharged patients with abnormal test results from the ED
    - Patients who had outpatient surgery

MR Must Contain Psych Hospitals

- EP 10 For Psych hospitals that use TJC for DS
- Progress notes are recorded by the following individuals involved in the active treatment of the patient:
- MD or DO responsible for the care of the inpatient, nurse, social worker or others involved in active treatment modalities
- The above individuals record progress notes at least weekly for the first two months of a patient's stay and at least monthly thereafter

Emergency Department Care

- EP21 - The MR of a patient who receives urgent or immediate care or treatment contains
  - Time and means of arrival
  - If patient left AMA
  - Remember to include documentation to comply with EMTALA law
  - Copy of any information made available to the practitioner or medical organization providing follow-up care

Emergency Department Care

- Conclusions reached at the termination of care
  - The patient's final disposition
  - Condition
  - Instructions given for follow-up care, treatment, and services
- EP 28 MR contains race and ethnicity
- EP 29 MR include patient self management goal and progress toward goals for hospitals that elect primary care medical home option

TJC FAQ Format for Collecting Race/Ethnicity

Rights and Responsibilities of the Individual (CAMH / Hospitals)

Format for collecting patient race and ethnicity data

New | December 10, 2012

Q. Can the patient's race and ethnicity data be collected in the same question?

A. Race and ethnicity data may be collected in either a 1- or 2-question format. Although The Joint Commission does not specify which categories to use when collecting the patient's race and ethnicity information, the monograph Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals[1] provides guidance to help hospitals collect these data elements (pages 36-37). Hospitals are encouraged to use the race and ethnicity categories from the Office of Management and Budget (OMB) and US Census Bureau, and to consult resources such as the Institute of Medicine report *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*[2] and the *Health Research and Educational Trust Disparities Toolkit*[3]. These resources recommend the collection of Hispanic ethnicity and the following race categories: Black or African American, White, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Some other race. However, organizations also have the flexibility to collect granular ethnicity categories as applicable to the population served. For example, if your organization has a large Asian population, you may want to consider collecting additional ethnicity categories such as Chinese, Japanese, Filipino, etc.

While the preferred method of data collection is to ask the Hispanic ethnicity question first, followed by the recommended race categories, it is acceptable to combine Hispanic ethnicity and race into the same question.

1. The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010. Available at http://www.jointcommission.org/Advancing_Effective_Communication/.
2. Ulmer C., McFadden B., Nerenz D.: *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press, 2009. Available at http://books.nap.edu/openbook.php?record_id=12696.
3. Hasnain-Wynia R., et al.: *Health Research and Educational Trust Disparities Toolkit*. Chicago, IL: Health Research & Educational Trust, 2007. Available at http://www.hretdisparities.org.

Surgery or High Risk Procedure RC.02.01.03

- Standard: The medical record documents operative or high risk procedures and the use of moderate or deep sedation or anesthesia
- EP1 - Hospital documents surgery or high risk procedures and/or the administration of moderate or deep sedation
- EP2 - Provisional diagnosis needs to be documented by LIP before surgery or high risk procedure

Surgery or High Risk Procedure

- EP3 - H&P is documented in MR before surgery or a high risk procedure
  - PC.01.02.03 EP5 requires H&P to be completed
    - Within 30 days prior to admission and update prior to surgery
    - Within 24 hours after inpatient admission
  - Important for both CMS and TJC
  - Audit compliance and make sure H&P on chart before patient goes to surgery unless it is an emergency

Surgery or High Risk Procedure

- EP5 - Operative or high risk procedure report is written or dictated upon completion and before patient is transferred to the next level of care
  - If dictated then can write a progress note, or use stamp or sticker immediately after the procedure
  - If physician performing the procedure accompanies the patient from the OR to the next unit or area of care then report can be written or dictated in that unit such as in the PACU

OP Report (CMS Also Requires)

- EP6 - Operative or high risk procedure report must include the following
  - Names of doctor or LIP who performed the procedure and assistants
  - Name of the procedure performed
  - Description and findings of procedure
  - Estimated blood loss (EBL) and if none write 0
  - Specimen removed
  - Postoperative diagnosis

Surgery or High Risk Procedure

- EP7 - If the full operative or procedure report cannot be entered into MR immediately then need to include:
  - Name of primary surgeon
  - Name of assistants
  - Procedure done with description of finding
  - EBL, specimens removed and postoperative diagnosis
  - Many use a stamp or if EMR a special field

Surgery or High Risk Procedure

- EP8 - MR must contain the following postoperative information
  - Vital signs (VS) and level of consciousness (LOC)
    - PC.03.01.05 EP1 - Requires that the patient's oxygenation, ventilation, and circulation are monitored continuously during surgery or during a high risk procedure
    - PC.03.01.07 EP1 - Requires that the patient's physiological status is evaluated immediately after surgery or as the patient is recovering from moderate or deep sedation

Surgery or High Risk Procedure

- Postoperative information (continued)
  - Medications, including IV fluids and any administered blood or blood products
  - Unanticipated events or complications (including blood transfusion reactions) and management

PACU Discharge Criteria

- EP9 - MR must document that the patient was discharged from post anesthesia care or from post-sedation by LIP responsible for their care or according to discharge criteria
  - Most hospitals have discharge criteria in the PACU such as the Modified Aldrete score or Modified Ramsey
  - If patient does not meet criteria then RN generally calls anesthesia provider for assessment and order to transfer out of PACU

PACU Discharge Criteria

- EP10 - MR documents the use of approved discharge criteria to determine readiness for discharge
  - PC.03.01.07 EP 4 - LIP discharge from recovery area or according to criteria approved by clinical leaders
  - Follow ASPAN standards
  - Patient has good Aldrete scores and goes to floor or ambulatory unit
- EP11 - Postoperative documentation includes the name of the LIP responsible for discharge

OR Register

- EP15 - OR Register must include the following (deemed status)
  - Patient name and identification number
  - Date and total time in surgery
  - Name of surgeon, assistants, and nursing personnel
  - Name of surgery
  - Frequent deficiency by CMS

OR Register

- Type of anesthesia and person administering it
- Surgery performed
- Pre and post-operative diagnosis
- Age of patient
- Note CMS requires post anesthesia assessment within 48 hours, whether inpatient or outpatient except CAH must do before leaving the hospital
- If outpatient may need to call at home if not seen before patient left the hospital

RC.02.01.05 Documentation R&S

- REMOVED FROM RC CHAPTER
- Standard - MR contains documentation of the use of restraint and seclusion (R&S)
- It is important to note that these apply to hospitals that do NOT use the TJC for deemed status so will not cover them in this presentation
- Therefore they only apply to hospitals such as the VA or Shiners
- TJC rewrote the R&S standards for hospitals to closely mirror the 50 pages of CMS restraint standards and TJC put the 10 standards in PC chapter

Summary List Ambulatory RC.02.01.07

- Standard - MR must contain a summary list for each patient receiving ambulatory care services
- All 4 EPs **DELETED** since duplicative of RC.01.01.01 EP 2 and 13,RC.02.01.01 EP2 and RC.02.01.03 EP1
- EP1 - The summary list is started by the third visit
- EP2 - Summary list includes; diagnosis, significant surgery or invasive procedures, ADRs, allergic drug reactions, and current medications including OTC and herbals

Summary List Ambulatory

- EP3 - Update the summary list whenever there is a change in diagnosis, medications, allergies or new procedure is done DELETED
- EP4 - Summary list needs to be readily available to practitioners who need access to the information to provide care and treatment DELETED

Verbal Orders Top Ten Problematic Standard

- **RC.02.03.07** Qualified staff receive and record verbal orders
  - There are 6 EPS but EP5 does not apply to hospitals
- Primary problem is that verbal orders are not signed off within the time frame set by the **state**
- If no state law then use to say how to sign off in 48 hours and now according to your policy
  - CMS allows any doctor on the case to sign off the verbal orders of any other physician on the case

Verbal Orders RC.02.03.07

- Standard - Qualified staff receive and record verbal orders (VO)
- Top problematic standard for both TJC and CMS
- Person who takes the VO signs the order, dates and times it
- Make sure when doctor signs off the verbal it is both dated and TIMED
- EP1 - Hospital P&P needs to identify who is authorized to receive and record VO, as allowed by law

Verbal Orders

- EP2 - Only authorized staff receive and record VO
  - Determine who can take and give VO
- EP3 - Documentation of VO includes:
  - Date and **time**
  - Name of person who gave order
  - Name of person who received and recorded the order
  - Name of person who implemented the order

Verbal Orders

- EP4 - VO are authenticated within the time frame specified by law (deemed status)
  - Follow your state law. Some have 24 hours, 48 hours or 7 days
  - If state does not have a state law then CMS use to say you had to authenticate in 48 hours but this was changed so now follow your P&P
  - Authentication means writing name, date, and time of the order
  - Can authenticate by electronic signature

Verbal Orders

- CMS allows PA and NP to sign VO if they could order it within their scope of practice
- EP6 - Documentation of VO includes time VO was received (DS)
  - Example: Lasix 20 mg PO daily

    VO Dr. Henry Smith/SDill RN 5-10-09 1315
- Remember to write down the VO and repeat it back

Discharge Information RC.02.04.01

- Standard: The hospital documents the discharge information
  - Amended 9-29-2014 adding EP 1 and 2
- EP1 Documentation in the medical record of swing bed patients must include discharge information provided to the resident and to the receiving facility (DS)
- EP2 Swing bed resides must make sure discharge information includes reason for discharge or transfer, treatment provided, diet,

Discharge Information RC.02.04.01

- EP2 Con’t of information that must be documented in swing bed patients
- Medication order, referrals provided to the resident, name of LIP who is responsible for care, nutritional, physical and psychosocial status and potential for rehab
- Medical findings, diagnosis, summary of care and progress toward goals
- Any advance directives, discharge instructions provided to the patient, nursing information that would useful in resident’s care

Discharge Information RC.02.04.01

- EP3 - In order to provide information to other care givers and facilitate continuity of care, the MR must contain a concise discharge summary
  - Not required for minor problems, as defined by MS, and a final progress note can substitute
  - Transfer summary may be substituted for discharge summary if patient transferred to different level of care within the hospital

Discharge Summary

- The discharge summary must contain
  - Reason for hospitalization
  - Procedures performed
  - Care and treatment provided
  - Patient’s condition and disposition at discharge
  - Information provided to patient and family
  - Provisions for follow up care
    - Example: did patient know diagnosis, what medications to take at home, diet to follow, activity level and what to do if symptoms should return

Discharge Summary

- Note that CMS requires a discharge summary for all patients so it may just be in the terminology
- It must contain the outcome of hospitalization, disposition of the case and provisions for follow up
- Transfer summary may be substituted for a discharge summary if transferred to a different level of care within the hospital and caregivers change or use a progress note

CMS Discharge Summary 468

- All medical records must have a discharge summary with outcome of hospitalization
- Disposition of the patient
- Provisions for follow up care
- Follow-up care includes post hospital appointments, how care needs will be met, and any plans for home health care, LTC, hospice or assisted living
- Can delegate to NP or PA if allowed by state law but physician must authenticate and date it and time it

The End! Questions???

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Standards

- American Society of Anesthesiologists (ASA) at www.asahq.org/publicationsAndServices/sgstoc.htm
- American College of Surgeons (ACS) at www.facs.org/
- American Association of periOperative Registered Nurses (AORN) at www.aorn.org
- American Society of PeriAnesthesia Nurses at www.aspan.org
- American Association of Certified Registered Nurse Anesthetists (CRNAs) at www.aana.org

American College of Surgeon

- Has positions statements that are reprinted from the Bulletin of the American College of Surgeons[1]
- Such as retained FBs after surgery, cell phone use in OR, blunt suture needles, statement on scope of practice, vendors in the OR, etc.
- Has guidelines such as standards in cardiac surgery and guidelines in office based surgery

[1]http://www.facs.org/fellows_info/statements/statement.html

AORN

- AORN position states such as correct site surgery, sponge counts, pediatric medication safety, fire prevention, on call, etc.
- Health care industry representative, creating a patient safety culture, role of scrub person, hypothermia, malignant hyperthermia, patient positioning, sterilization, etc.

AORN
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+ AORN Standards and Recommended Practices
+ AORN Position Statements
+ PNDS and Standardized Perioperative Record
+ Tool Kits
+ AORN Library
+ Nurse Consultation
+ Nursing Research
+ Safety Resources

Announcements

Two new position statements were approved by the House of Delegates at the 55th Annual Congress in Anaheim:

- Surgical Smoke and Bio-Aerosols

AORN Position Statements

AORN position statements articulate the Association's official position or belief about certain perioperative nursing-related topics. Position statements are authored by a AORN Board of Directors appointees and are approved by the Board and the House of Delegates.

AORN has published position statements on the following topics:

- Policy for Sunset of AORN Position Statements
- Allied Health Care Providers and Support Personnel in the Perioperative Practice Setting
- AORN Revised Statement on Patients and Health Care Workers with Bloodborne Diseases
- Statement on Correct Site Surgery
- Creating a Patient Safety Culture
- Statement regarding Criminalization of Human Errors in the Perioperative Setting
- Perioperative Care of Patients With Do-Not-
- Statement on One Perioperative Registered Nurse Circulator Dedicated to Every Patient Undergoing A Surgical or Other Invasive Procedure
- Orientation of the Registered Professional Nurse to the Perioperative Setting
- Orientation of the Surgical Technologist to the Perioperative Setting
- Statement on Patient Safety
- Pediatric Medication Safety
- Perioperative Advanced Practice Nurse

ASPAN

- Has position statements such on overflow patients in PACU, use of UUAPs, safe medication administration, perianesthesia safety, postoperative N&V
- Has standards of perianesthesia nursing practice such as phase I level care, staffing guidelines, safe transfer of care, documentation requirements, etc.

Position Statements

The American Society of PeriAnesthesia Nurses has formulated the following position statements:

- Cultural Diversity and Sensitivity in Perianesthesia Nursing Practice
- Medical-Surgical Overflow Patients in the Postanesthesia Care Unit (PACU) and Ambulatory Care Unit (ACU)
- Visitation in Phase I Level of Care
- Smallpox Vaccination Programs
- Entry into Nursing Practice
- Fast Tracking
- Minimum Staffing in Phase I PACU
- On Call/Work Schedule
- Perianesthesia Advanced Practice Nursing
- The Perianesthesia Patient with a Do-Not-Resuscitate Advance Directive
- Registered Nurse Utilization of Unlicensed Assistive Personnel
- A Joint Position Statement on ICU Overflow Patients developed by ASPAN, AACN and ASA's Anesthesia Care Team Committee and Committee on Critical Care Medicine and Trauma Medicine
- Nursing Shortage
- Safe Medication Administration
- Perianesthesia Safety

AHIMA Guidelines for Defining the Legal Record

Data and Documents to Be Considered Part of the Record

- Advance directives
- Allergy records
- Alerts and reminders (see "Alerts, Reminders, and Pop-Ups," above)
- Analog and digital patient photographs for identification purposes only
- Anesthesia records
- Care plans
- Consent forms for care, treatment, and research
- Consultation reports
- Diagnostic images
- Discharge instructions
- Discharge summaries
- E-mail messages containing patient-provider or provider-provider communications regarding care or treatment of specific patients[5]
- Emergency department records
- Fetal monitoring strips from which interpretations are derived
- Functional status assessments
- Graphic records
- History and physical examination records
- Immunization records
- Instant messages containing patient-provider or provider-provider communications regarding care or treatment of specific patients[6]
- Intake and output records
- Medication administration records
- Medication orders

Documents Not Included in the Legal Health Record

Administrative Data and Documents

Administrative data and documents should be provided the same level of confidentiality as the legal health record. However, administrative data should not be considered part of the legal health record and would not be produced in response to a subpoena for the medical record. Healthcare organizations might more appropriately consider some administrative data and documents as working documents.

Administrative data are patient-identifiable data used for administrative, regulatory, healthcare operation, and payment (financial) purposes. Examples of administrative data include:

- Abbreviation and do-not-use abbreviation lists
- Audit trails related to the EHR
- Authorization forms for release of information
- Birth and death certificate worksheets
- Correspondence concerning requests for records
- Databases containing patient information
- Event history and audit trails
- Financial and insurance forms
- Incident or patient safety reports
- Indices (disease, operation, death)
- Institutional review board lists
- Logs
- Notice of privacy practices acknowledgments (unless the organization chooses to classify

This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.

Thanks for attending!

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