Clinical Records PC.C.15

Regulation(s):	42 CFR 418.104; 418.104(a)(1-7); 418.104(b); 418.104(c); 418.104(d); 418.104(f)
L-Tag(s):	670 - 681, 685

POLICY: A clinical record is established and maintained for every patient receiving care and services from Lifesong Hospice and Palliative Care. The record is complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

PROCEDURE:

1. Entries are made in the clinical record for all services provided (both those services provided directly and through contracted providers) in a standardized format and are legible, clear, complete and signed and dated by the person providing the services.

2. Only authorized individuals can make entries in patient clinical records and all signatures are authenticated to ensure the author is who s/he claims to be. Stamped physician signatures are not accepted. The hospice will maintain a log of physician and staff signatures for authentication purposes.

3. Each patient's clinical record includes, at a minimum, the following:
    a. identification data;
    b. referral information and available, pertinent medical history;
    c. initial assessment and comprehensive assessments;
    d. the initial plan of care and updated plans of care
    e. clinical notes;
    f. signed copies of the notice of patient rights, informed consent and election statement;
    g. acknowledgement of receipt of the hospice's Notice of Privacy Practices;
    h. documentation of the patient's responses to medications, symptom management, treatments and services;
    i. outcome measure data elements;
    j. physician certification and recertification statements;
    k. signed physician orders;
    l. copies of advance directives (if applicable); and
    m. copies of clinical records of other providers as appropriate (e.g., attending physicians, ER visits, hospitalizations, nursing facility notes, etc.)

4. Access to patient clinical records is restricted to members of the interdisciplinary group (IDG) and employees who require such access to perform their jobs effectively.

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5/22/18	11/2018		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**

5. A patient's entire clinical record may only be used or disclosed in accordance with the hospice's policies and procedures related to uses and disclosures of protected health information.

6. Clinical records are safeguarded against loss or destruction.

7. Lifesong Hospice and Palliative Care has a zero-tolerance policy for falsification of clinical records.

8. When an error is made in the clinical record, it may only be corrected by drawing a single thin line through the error with the initials of the individual making the correction and the date of the correction. White-out liquid or tape, erasure, or obliteration of the error by multiple cross-outs and/or write-overs is not allowed.

9. No corrections are allowed on the Hospice Election of Benefit form.

10. Unlocking and altering (i.e., by adding to or deleting from) electronic documentation is expressly prohibited. Any corrections to the record should be documented in an "addendum."

11. Clinical records are easily retrievable and readily accessible when requested by appropriate authorities.

12. Clinical records are retained and protected, at a minimum, for six (6) years after the death or discharge of a patient.

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