Section 6 — Medical Records

Policy 6.1 — Guidelines for Documentation

Policy Statement

Legacy requires that every rehabilitation therapy record follow a set pattern in which each record is complete, accurately documented, readily accessible, and systematically organized. Such records provide information regarding the patient to other members of the treatment team and ensure reimbursement for the clinical services provided. LHS uses a software program for electronic documentation.

Procedure

A. Initial Evaluation – Evaluations are initiated according to facility requirements. Evaluations must occur as the result of a physician order. The evaluation must always demonstrate that therapists' skilled services were required to gather the information presented. The rehabilitation problem should be stated clearly, quantified, and must include the following:

- Past medical history.
- Prior functional level.
- Reason for referral to rehabilitation.
- Acute onset for condition prescribed.
- Cognitive ability to participate in therapy program.
- Objective measurable and functional baseline of performance.
- Discharge plan.

In addition, short- and long-term goals, rehabilitation potential, estimated frequency, and duration of treatment must be stated.

A. Daily Documentation of Treatment – A daily notation is made of the modalities or procedures patient receives during treatment session(s). This notation is made in the electronic medical record, and indicates specific procedures received and the number of therapy minutes client received. A narrative entry is required documenting objective and subjective responses to treatment. Any illness or significant event occurring during treatment—or an adverse response to treatment—is documented and communicated to facility medical personnel. Documentation should reflect this notification.

Daily entries can also include, as appropriate, communication with nursing, social services,

family, and physician. Daily entries may be written by the therapist assistant.

If scheduled treatment is not rendered, the reason(s) the session is missed must be documented.

B. Weekly Summary – A summary of patient progress is required at least once weekly (7 days) for Medicare A skilled services. Objective, specific gains are recorded along with changes in the treatment program. An indication of further anticipated reasonable goals, and dates of services provided, with procedures and modalities should be present. Weekly progress notes may be written by licensed therapists or assistants. Therapists must cosign notes written by assistants, but only if the state practice act requires it or the patient's treatment plan is changed. This practice does, however, provide structure that ensures therapist review of patient's progress and treatment plan with the licensed assistant at least weekly and is encouraged when possible.

C. Progress Note/10th Visit – A summary of patient progress is required no later than the 10th visit or as required by state practice acts.

D. Monthly Review or Update of Therapy Plan – The physician must be provided with a 30-day summary of the patient's progress and current status for Medicare A, and every 30 – 90 days for Rehab Agency. At this time the therapist reviews the patient's goals and treatment plan and makes any revisions as a result. The physician must sign this summary to verify the plan of care is updated in consultation with the attending physician (before the physician's signature is obtained, a copy of the updated plan is kept on the chart).

E. Discharge Summary – These are to be written on the last day of treatment when possible. Since the discharge must be completed by the therapist, the Discharge Summary is expected to be completed by the next facility visit at which the supervising therapist is present. Discharge summaries are to include duration of treatment, problems treated during therapy, ability levelson initial evaluation and on discharge, and recommendations for follow-up. Reference is made regarding any conversation with discharge care provider (i.e., family member, out-patient department, home-health provider).

F. Patient-Care Plan - As required by each facility, after completion of the initial evaluation, the therapist will participate in the patient's care-plan development. Goals for therapy and other facility disciplines/departments should be included.

G. Other Documentation Guidelines:

1. Late Entries to Records – Licensed rehab personnel may make additions to the medical record as long as they are appropriately labeled "late entry," and dated and signed when written.

2. All areas of documentation in the electronic medical record must be complete.

(***Effective Date: April 2006; Revised Date: January 2016.***) (***Return to "Contents"***)

Policy 6.2 — Clinical Documentation

Policy Statement

Clinical documentation must be technically complete, timely, accurate, clinically appropriate, thorough, and compliant with corporate and facility standards, and state, federal, and private-funding-source regulations.

Procedure

Appropriate rehabilitation personnel complete required documentation using Legacy's electronic medical record system.

H. Required Clinical Documentation

- Physician's Orders
- Assessment / Initial Plan of treatment Discipline-specific Assessment Forms
- Daily Treatment Notes
- Progress Notes – OT, PT, and ST
- Re-Assessment / Updated Plan of Care
- Intent to Discharge — in required settings
- Discharge Summary
- Discharge Orders — in required settings

I. Documentation Expectation

Legacy's electronic medical-record system provides templates for all required documentation: Initial evaluation and Plan of care, Updated Plan of Care, Progress Notes, Discharge Summary. Each template contains all components necessary to meet regulatory requirements.

Employees are expected to complete all documentation according to education and training provided during orientation and additional training afterward. Complete records must reflect the medical necessity, skill and sophistication of services provided and should be of sufficient quality to support review by MAC, RAC, or other payor or regulatory body.

(***Effective Date: November 2003; Revised Date: January 2016.***) (***Return to "Contents"***)

Policy 6.3 — Electronic Signatures

Policy Statement

Legacy uses electronic signatures for medical records as allowed by the Medicare Program and in accordance with state and local laws. Electronic signature, an automated function that replaces a handwritten signature with a system generated signature statement, is used for medical records as a means for authenticating transcribed documents, computer-generated documents and electronic entries. System-generated electronic signatures are considered legally binding as a means to identify the author of medical-record entries and confirm the contents are what the author intended.

Procedure

A. The following types of electronic signatures can be used:

- Electronic signature statement (digital signature).
- Digitized signature (actual signature converted to electronic image).

If the application allows auto-authentication or auto-signatures this functionality is prohibited. The author of the entry is required to review/validate the entry before applying electronic or digitized signature.

All employees delivering direct patient care are required to sign a *Master Signature Log Form* (found on the intranet under Downloads/Operations/RD documents), which matches the electronic signature to the individual and is maintained in the rehab department.

B. Security

Confidentiality statement – Any employee authorized to use electronic signature must sign a statement attesting that he or she is the only one with access to the signature code, that the electronic signature is legally binding, and that passwords and PIN numbers will not be shared.

Passwords – All users have their own unique user ID and password. Passwords must be at least six characters long and include at least one number or symbol. Passwords expire every 90 days and must be reset. They cannot be repeated for at least five cycles.

Personal Identification Numbers (PIN) / Secondary Passwords – PIN numbers and secondary passwords are assigned when possible for use with electronic signatures for another level of security. PIN numbers or secondary passwords are not viewable on any screen.

Before assigning the unique user name the system administrator shall verify the user and ensure the user has signed the facility specific *Rehab Master Signature Log Form .*

Systems using electronic signatures based on use of user IDs and passwords and described in this policy, must use additional controls to ensure the security and integrity of each user's electronic signature:

1. Contact tech support in the case of a lost, stolen, missing or otherwise compromised documents or devices that bear or generate identification code or password information and use suitable, rigorous controls to issue temporary or permanent replacements.
2. Use safeguards to prevent unauthorized use or attempted use of passwords and identification codes.
3. Test or use only tested devices, such as tokens or cards that bear or generate identification code or password information to ensure they function properly and are not altered.

(***Effective Date: November 2008; Revised Date: February 2011.***) (***Return to "Contents"***)

Policy 6.4 — Retention, Archiving, and Disposal of Patient Information

Policy Statement

Legacy adheres to all state and federal guidelines regarding retention, archiving and disposal of patient information.

Procedure

It is the responsibility of the Agency Administrator and assigned personnel to purge patient-care files at the end of each month as follows:

Patient data in paper records and electronic media, which are not used for active patient care or payment processes, may be archived until retention requirements are met.

Only primary medical and financial records may be archived. All original health-information records must be retained for at least 10 years from the date of the patient's last encounter.

The contents of "shadow" records should be destroyed after it is determined they contain only duplicates of records maintained elsewhere, and do not contain original materials.

No primary records of any type belonging to Legacy may be destroyed until 1. records meet retention requirements established by the state in which therapy services are delivered, and 2. written authorization is obtained from Legacy's Privacy Officer.

Patient medical and financial records may only be destroyed in the ordinary course of business; no entire record may be destroyed on an individual basis. No records relevant to or involved in open investigations, audits, or pending litigation may be destroyed, removed, or otherwise discarded.

Storage Areas

On-Site: An area inside the clinic must be physically secure and environmentally controlled, to protect records from unauthorized access and damage or loss from temperature fluctuations, fire, water damage, pests, and other hazards.

Off-Site: Archived Inactive Records are stored at Legacy's corporate offices, which meet the physical and environmental requirements previously stated.

Complete the *Patient Files to be Archived Form* (on the intranet under Downloads/Operations/RD documents) and email it as an attachment to: pomm@legacyhealthcare.net

Include the following information so LHS can create a shipping label and email it to you:

- Length x Width x Height
- Weight
- Ship FROM Address
- Facility Name
- Street Address
- City, State, Zip Code
- Date for requested UPS pick up

When the label request and the *Patient Files to be Archived Form* are received LHS sends you a shipping label and requests UPS pick up. On receipt of the shipment corporate office personnel confirm receipt of patient files received previously reported on the *Patient Files to be Archived Form*. Any discrepancies are reported promptly to the facility Rehab Director and the Area Rehab Manager.

Archiving Inactive Records: Patient medical records to archive: Inventory records so they may be retrieved, if needed, and for destruction purposes after the retention requirement is met. The inventory must be retained in the rehab department and should include:

1. Clinic name.

Patient's name.

Patient's medical record number.

Dates of service included in the record.

Box number or other location indicator.

Inventories may be in paper or electronic format. Retain the inventory list in a central location for easy access.

Preparing Records Containing Protected Health Information for Storage:

- Only primary records should be stored.
- Remove records from active files by year and place them in approved storage boxes in alphabetical order.
- Prepare an inventory list of each box contents, including all items required above for each record.

Destruction of Nonprimary Records:

Paper records and records stored on electric media must be either immediately shredded, pulverized, or electronically purged, or placed in locked or otherwise secure storage for controlled shredding/destruction and recycling later.

Destruction of Primary Records:

- Create a Record Destruction Log, listing all medical records to be destroyed, date and method of destruction, signatures of individuals witnessing the destruction.
- Record Destruction Logs must be maintained for the life of the institution, and may only be maintained in paper formats.

(***Effective Date: November 2006; Revised Date: February 2013.***) (***Return to "Contents"***)

Section 7 — Infection Control and Safety

Policy 7.1 — Infection Control — General

Policy Statement

Legacy provides employees and patients with a safe and clean work and service environment. Legacy adheres to local, state, and federal regulations regarding work safety and infection control.

All Legacy employees are educated on all of Legacy's Infection-Control Policies and general facts regarding blood-borne pathogens on initial orientation and, minimally, once a year thereafter.

Procedure

A. Legacy employees must participate in a training program on Infection Control Policies and Procedures and dangers of blood-borne pathogens at orientation and annually thereafter.

B. Annual in-service training records are maintained by the Rehab Director at the facility and maintained at the corporate office.

C. Training records will include the following:

1. Date of the training session.

   Contents/summary of the training session.

   Names and qualifications of persons conducting the training.

   Names and job titles of all persons attending the training sessions.

D. An Equipment Cleaning Log is completed and initialed by the assigned staff member(s) to document that proper sanitation procedures are followed for all equipment used by patients and staff. This log is monitored routinely by the rehab director to ensure compliance.

E. To ensure compliance with local, state, and federal regulations for work safety and infection control, the facility Infection Control Policy and Procedure may supersede Legacy's Infection Control Policy and Procedure when necessary.

(***Effective Date: March 2004; Revised Date: January 2016.***) (*Return to "Contents"*)

Policy 7.2 — Infection Control Committee

Policy Statement

Legacy establishes an Infection Control Committee that meets and conducts business in compliance with Medicare regulations and company procedures. CFR 485.725(a) Conditions of Participation: Infection Control.

Procedure

A. The Assistant Administrator assigns members of the Infection Control Committee annually and identifies members on the Infection Control Member Form.

B. The Infection Control Committee meets at least annually to address issues related to infection-control procedures.

C. The agenda for the Infection Control Committee meetings include:

1. Review of existing policies and procedures for investigating, control and preventing exposure to and transmission of infection.

Monitoring employee compliance with infection-control policy and procedures and employee orientation and training regarding policy and procedures.

Review of schedules for and documentation of employee orientation as documented on the employee orientation checklist.

Monitoring of in-service training as documented on the infection-control in-service log provided.

D. Minutes and recommendations from committee meetings are provided to the Advisory Board for review and action as needed. Minutes are filed for reference with the Administrator.

INFECTION CONTROL COMMITTEE

The name and title of members of the Infection Control Committee are as follows: