SUBJECT: MEDICAL RECORDS	REFERENCE #11001
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- _____ HHA shall maintain a written and/or electronic medical record containing past and current information for every patient accepted by the HHA and receiving Home Health services.

- All medical records shall adhere to current medical record documentation standards of practice and reflect true and accurate information about the patient, the patient's condition and any activities of the supplier or its agents.

- Information contained in the medical record shall be readily available to the physician(s) issuing orders for the patient's Plan of Care and appropriate HHA staff.

- Falsifying information on the medical records to justify reimbursement for an item or services is prohibited and grounds for immediate termination.

SUBJECT: MEDICAL RECORD CONTENT POLICY	REFERENCE #11002
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 6
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- _____ HHA shall ensure that the medical record contains the following information (not all inclusive):
  - Patient identification and contact information
  - Name and contact information of the patient's physician(s)
  - Contact information for the patient, patient's representative (if any) and patient's primary caregiver(s)
  - Diagnosis(es)
  - Consent/Authorization to Treat forms
  - Release of Information forms
  - Advance Directives
  - Information from recent hospitalization(s) or other institution(s) previously providing care, including admission/discharge dates, as applicable
  - Medication orders
  - Medication administration
  - Dietary orders
  - Treatment orders
  - Activity orders
  - Comprehensive Assessment(s)
  - Plans of Care
  - Types of services and equipment required
  - Frequency of visits

- Referral source
- Accurate documentation of the course and results of care, treatment and services - signed and dated clinical and progress notes
- Patient response to services and interventions provided
- Copies of summary reports sent to the physician(s), if applicable
- Discharge/Transfer summary

- All entries in the medical record shall be dated, timed and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented.

PROCEDURE:

- _____ shall be responsible for collecting sufficient information to identify the patient. The information shall be documented on the face sheet, which is a permanent part of the patient's record. Sufficient information shall include, but may not be limited to:
  - Patient’s name
  - Patient’s contact information, including address
  - Gender
  - Primary language spoken
  - Communication needs
  - Date of birth
  - Authorized representatives (if any) and their contact information
  - Patient's primary caregivers (if any) and their contact information

- Legal status of patients receiving behavioral healthcare services
- Allergies
- Patient's physician(s) and contact information

- A History and Physical (H&P) examination shall be completed within_____hours of admission by the appropriate practitioner privileged to perform H&Ps. The H&P shall be obtained from the patient when possible and include:
  - Chief complaint
  - History of present illness
  - Relevant past medical history, family and social history
  - Allergies to medications and foods
  - Review of systems, including a minimum review of the cardiovascular, respiratory, genitourinary and gastrointestinal systems
  - Findings of assessment and reassessment
  - A statement of initial diagnosis, diagnostic impressions and condition
  - Rehabilitation potential
  - Functional limitations
  - Prognosis
  - Plan of Care
  - Signature of the physician (which authenticates the H&P exam)

- There shall be evidence in the patient's medical record of informed consent documentation and all other appropriate legal documentation obtained at admission and/or throughout the patient’s time on HHA service.

- There shall be evidence of known Advance Directives in the patient's medical record.
- There shall be documentation of all interventions/services provided and the patient and family's responses to those interventions/services.

 Clinical observations shall be made in the progress notes.

 Goals in the patient's Plan of Care and the patient's progress toward meeting goals shall be documented in the medical record.

- Nurses' notes and entries by nonphysicians shall contain pertinent and meaningful information and observations.

 All reports of diagnostic and therapeutic procedures, tests and their results shall be documented and authenticated in the medical record.

 All medications ordered shall be documented in the medical record.

- Medication administration shall be documented in the patient's medication record to include:

  - Strength
  - Dose, rate of administration
  - Route
  - Administration devices used
  - Any adverse drug reaction
  - Date and time of administration
  - Name and title of person performing medication administration

 Summary reports shall be maintained in the medical record.

- Reports of Pathology and Clinical Laboratory examinations, Imaging/Radiology, and any other diagnostic or therapeutic procedure shall be filed in the medical record within _____ of completion.

- Any complications shall be documented.

- Patient and family education shall be documented by all disciplines, as applicable, in the patient's medical record.

- Communication in person, via e-mail or telephone with the patient, legal representative, or patient caregiver(s), shall be documented in the patient's medical record.

- All patient-generated information shall be documented (i.e., information entered into the record over the Internet or various forms of electronic media from laboratory or other diagnostic avenues, pre-visit clinical data or other types of information).

- Contact information for the primary care practitioner or other healthcare professional who shall be responsible for providing care and services to the patient after discharge from the HHA.

- The Discharge Summary or Transfer Summary shall include, but not be limited to:

  - Admitting diagnosis/reason for admission

  - Final diagnosis and any associated diagnosis

  - Patient identifying information, including patient's emergency contact

  - Summary of the patient's diagnoses as well as physical, mental and emotional status at the time of transfer or discharge.

  - The date, initiation and reason for transfer or discharge.

  - The extent to which goals were met and any referrals made.

  - Documentation of notification of all physicians issuing orders for the HHA Plan of Care, patient, patient's legal representative (if any) and family regarding the termination of service.

- Contact information of any healthcare practitioners providing ongoing care/service following discharge/transfer
- Any instructions given to the patient/legal representative at the time of discharge or transfer

- The medical record must be completed within_____days post patient discharge from the HHA.

SUBJECT: ENTRIES IN THE MEDICAL RECORD	REFERENCE #11003
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- _____ HHA shall ensure that entries in the medical record are made only by authorized individuals.
- All entries into the medical record must be legible, clear, complete and appropriately authenticated, dated and timed.
- Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

PROCEDURE:

- _____ shall be responsible to monitor all medical records for appropriate documentation in the medical record.
- Individuals authorized to document in the medical record are as follows:
  - Progress notes:
    - Physicians
    - Nurses
    - Designees from the following:
      - Pharmacy
      - Physical Therapy
      - Nutritional Services
      - Medical Social Service
      - Any other service providing care for the patient who has a need to communicate patient progress

- Physician's orders:
  - Physicians
  - Nursing staff accepting telephone or verbal orders from the caregiver
  - Pharmacy

- All entries in the medical record shall be authenticated by:
  - A handwritten signature and title (occupation), **OR**
  - A secured computer entry by a unique identifier of a primary author who has reviewed and approved the entry.

- Other departments such as Nutritional Services, Nursing, Utilization Management, and others, who have their own designated progress notes in the medical record, shall be responsible for the documentation on their forms.

- Any department wishing to create new forms, or revise any existing forms must submit new drafts, or revisions, to_____for approval. State the purpose of the form, justification for its use and if it is replacing an existing form. This information may be submitted in a memo or in person.

NOTE:

Your Agency must define which entries made in the medical record by nonindependent practitioners require countersigning in compliance with law and regulation.

SUBJECT: PHYSICIAN SIGNATURE REQUIREMENTS	REFERENCE #11004
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

_____ HHA shall ensure that a system is in place to protect against modification, misuse or abuse of physician signatures.

PROCEDURE:

- _____ HHA requires a legible identity in the form of a signature for all medical orders or other medical record documentation.
- Signatures may be in the form of a handwritten or electronic signature.
  - There shall be safeguards in place to prevent unauthorized access to patient records when an electronic signature is used.
  - Electronic signatures shall be date-stamped.
  - Handwritten signatures shall be dated per organizational policy.
- Rubber stamp signatures are <u>not</u> acceptable.

NOTE:

Please review State licensure and practice regulations, as they may be more restrictive.

SUBJECT: CORRECTIONS TO THE PAPER MEDICAL RECORD	REFERENCE #11005
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- All medical record entries shall be made as soon as possible after care, treatment or services have been provided.
- A medical record entry shall never be made in the medical record in advance of the care, treatment or service provided to the patient.
- Pre-dating or backdating an entry in the medical record is prohibited.
- Handwritten entries shall be made with permanent black or blue ink, with medium point pens.
- All entries in the medical record must be legible, dated, timed and authenticated.
- Incorrect documentation shall not be destroyed in any form or fashion. Modifications to the record shall adhere to the following format:
  - If information in the medical record must be corrected or revised, a single horizontal line shall be drawn through the incorrect entry; date and sign next to the information that needs to be corrected.
    - Write the correct information as close to your signature as possible.
  - Do not write over the original medical record entry to obscure what was originally written.
  - Do not erase any entries in the medical record.
  - The use of white-out is prohibited.

- When a Comprehensive Assessment is corrected, the original assessment record, as well as all subsequent corrected assessments, shall be maintained in the patient's clinical record.

- If maintained electronically, the HHA has the capability to retrieve and reproduce a hardcopy of these assessments upon request.

    - It is acceptable to have multiple corrected assessments for an OASIS assessment, as long as the OASIS and the clinical record are documented in accordance with the requirements at 42 CFR 484.110, Clinical Records.

NOTE:

Check specific state rules and regulations and the organization's legal counsel.

SUBJECT: ACCESS AND MAINTENANCE OF THE ELECTRONIC HEALTH RECORD	REFERENCE #11006
	PAGE: 1 OF: 1
DEPARTMENT: HOME HEALTH	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- _____ HHA shall create a complete electronic health record (EHR) for each patient. Images of the paper record shall be accepted into the secure electronic document system for archiving and access controls, consistent with all federal and state rules and regulations.
- Each page of each document in the EHR must have legible patient identifiers.
- Only authorized staff shall have access to databases and/or images of the EHR file system.
- Medical Records shall ensure the quality of all scanned documents into the electronic document system.
- After the paper medical record is accepted into the EHR, the paper medical record shall be boxed and stored at_____for_____years.
- Medical Records/Administrator shall maintain a master list of stored medical records boxes, by date and contents of each box.
- Medical Records/Administrator must authorize the retrieval of any boxes of stored medical records.
- Medical Records staff shall have access to Adjust Document indexes in the system for re-indexing documents and to delete documents. This access shall be audited through the system audit trail.
- Backups to safeguard the EHR system shall be performed by_____.
- All servers shall be located in secure areas. Passcodes are required to enter these areas.
- Quality Assessment and Performance Improvement (QAPI):
  - _____ shall review a minimum of__ medical records scanned and indexed by each clerk to ensure documents have been scanned according to established standards.
  - Outcomes shall be shared with the appropriate staff members and QAPI committee, and developed into inservices as needed.

SUBJECT: LATE ENTRIES TO THE ELECTRONIC HEALTH RECORD	REFERENCE #11007
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

DEFINITION:

(American Health Information Management Association)

- Late Entry: Only applies to documentation within the electronic health record (EHR) that is entered after care, treatment or services have been provided.
  - Late entries apply to direct documentation only, i.e., physician orders, progress notes, Nurses' Notes.

POLICY:

- _____ HHA staff shall make every attempt to document in the medical record in a timely manner.
- If an entry in the medical record is missed or not written, the staff member may enter a late entry into the medical record.
- The late entry must be documented as soon as possible.

PROCEDURE:

- When entering a late entry into the medical record, staff shall:
  - Identify the new entry as a "late entry"
  - Document the current date and time
  - Authenticate the late entry
  - Identify or refer to the date and circumstance for which the late entry or addendum is written

REFERENCES:

- Centers for Medicare and Medicaid Services (CMS). (2015). Medicare Program Integrity Manual - Chapter 3 - Verifying Potential Errors and Taking Corrective Actions. 3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

- American Health Information Management Association (AHIMA). (2012). Amendments, Corrections, and Deletions in the Electronic Health Record Toolkit.

SUBJECT: ADDENDUM TO THE ELECTRONIC HEALTH RECORD	REFERENCE #11008
	PAGE: 1 OF: 2
DEPARTMENT: HOME HEALTH	EFFECTIVE:
APPROVED BY:	REVISED:

DEFINITION:

(American Health Information Management Association)

- Addendum: New documentation used to **add** information to an original entry. Addenda shall include the current date and reason for the additional information being added to the medical record.
  - Examples of documentation errors that are corrected by addendum include wrong date, location, duplicate documents, incomplete documents or other errors.

POLICY:

- Staff shall make every attempt to correctly identify the patient and medical condition before documenting in the medical record.
- Addenda must be used at a minimum.
- Once a document has been signed (authenticated), the only way to correct or revise the documentation is to provide an addendum.
- When writing an addendum, complete it as soon as possible after the original note; include the current date and reason for the additional information being added to the medical record.

PROCEDURE:

- The following information must be documented, by the healthcare provider, when completing an addendum to the medical record:
  - Patient name
  - Date of service
  - Medical record number
  - Original report the addendum is to be attached to

- Date and time of the addendum
- Reason for the additional information being added to the health record
- Authentication by the healthcare provider

- Medical Records staff shall review each addendum for appropriateness before attaching it to the original report.
- Medical Records staff shall ensure the addendum has all of the necessary components as listed above.

NOTES:

- Check specific state rules and regulations and the organization's legal counsel
- The healthcare organization should have processes in place to forward the addenda to any other provider where the information has been sent to ensure that providers have the most up-to-date information.
- This policy and procedure must be specific to the electronic health record (EHR) system used in the healthcare organization.
  - There are many different ways to enter a correction within the EHR, and it may depend on the specific system the organization has implemented (i.e., the original entry has a single line through it or appears in a different color).
  - The healthcare organization's electronic health record system should have the functional capabilities to lock a record from any further editing once the final signature has been applied.

REFERENCE:

American Health Information Management Association (AHIMA). (2012). Amendments, Corrections, and Deletions in the Electronic Health Record Toolkit.

SUBJECT: AMENDMENT TO THE ELECTRONIC HEALTH RECORD	REFERENCE #11009
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

DEFINITION:

(American Health Information Management Association)

- Amendment: Documentation meant to **clarify** health information to a dictated report or direct data entry after the final signature has been obtained. An amendment is made after the original documentation has been completed by the provider.
  - Some organizations may choose to implement policies and procedures that do not allow amendments. In that case, any clarification would require an addendum.

POLICY:

- Staff shall make every attempt to correctly identify the patient and medical condition before documenting in the medical record.
- Amendments must be used at a minimum.

PROCEDURE:

- The healthcare provider shall:
  - Identify the correct report or direct data entry in need of clarification
  - Notify Medical Records of the need for an amendment
  - Complete the amendment, including current date, time and authentication
  - Forward the amendment to Medical Records for inclusion in medical record

- Medical Records shall:
  - Locate the original document
  - Attach the amendment to the original document
  - Ensure that the amendment has been signed, dated and timed
  - Attach amendment to the electronic health record
- Medical Records shall track the use of amendments as a part of the organization's Quality Assessment and Performance Improvement (QAPI) process and shall report violations to _____.

NOTES:

- Check specific state rules and regulations and the organization's legal counsel.
- This policy and procedure must be specific to the electronic health record (EHR) system used in the healthcare organization.
  - The system should have the functional capabilities to lock a record from any further editing once the final signature has been applied.

REFERENCE:

American Health Information Management Association (AHIMA). (2012). Amendments, Corrections, and Deletions in the Electronic Health Record Toolkit.

SUBJECT: LEGIBILITY OF MEDICAL RECORD DOCUMENTATION	REFERENCE #11010
	PAGE: 1 OF: 2
DEPARTMENT: HOME HEALTH	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

To maintain an accurately written and promptly completed medical record for each inpatient and outpatient.

POLICY:

- _____ HHA shall set legibility standards for medical record documentation and shall monitor compliance with these standards as part of our Quality Assessment and Performance Improvement (QAPI) and medical error reduction activities.

- This policy shall be applicable to all documentation within the medical record.

PROCEDURE:

- Whenever possible, all consults, histories and physicals, interpretations of diagnostic testing, and post-operative/procedure results shall be dictated.

- Only abbreviations listed in the organization's list of approved abbreviations shall be allowed for use in medical record documentation.

- Medication Orders:

  - Shall include a brief notation of purpose.

  - All prescription orders shall be written in the metric system.

    - "Units" shall be spelled out.

  - The order must include drug name, exact strength or concentration, dose, frequency, and route.

  - A leading zero must precede a decimal expression of less than one.

- A terminal zero shall not be used after a decimal.
- Prescribers shall avoid the use of abbreviations for drug names and Latin directions for use.
- The age, height and weight of the patient (especially geriatric and pediatric patients) shall be included where appropriate.

- If a healthcare professional writes an order that is not legible, the order must be clarified with the healthcare professional prior to implementation.
- Clarification of orders shall be documented on the order sheet as a "clarification," timed and dated and signed by the healthcare professional receiving the clarification.
- Failure to clarify an illegible order shall result in employee counseling.
- Legibility shall be monitored via concurrent and retrospective medical record review:
  - Unresolved legibility issues with physicians and allied healthcare professionals shall be forwarded to the Medical Director.
  - Unresolved legibility issues with other healthcare professionals shall be forwarded to their respective department managers and shall be included as part of the annual review process.

SUBJECT: MAINTENANCE AND RETENTION OF MEDICAL RECORDS	REFERENCE #11011
	PAGE: 1 OF: 6
DEPARTMENT: HOME HEALTH	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

- To maintain the integrity and security of medical records while allowing access to the records by authorized staff.

- To safeguard medical records against loss, destruction and tampering.

POLICY:

- Paper and/or electronic medical records shall be maintained and stored in a secure manner that prevents loss, damage or tampering, while simultaneously allowing for ease of access for authorized staff.

- Only authorized staff, including employees and contracted staff, with a "need to know" are permitted access to patients' medical records.

- Unique computer passwords shall be assigned to authorized staff and shall be kept confidential by each individual staff member. The passwords shall be stored within the HHA in a confidential manner and shall be changed on a regular basis as determined by the HHA.

- The Medical Records Coordinator/Department shall be responsible for maintaining and retaining patients' medical records in a manner consistent with the HHA's policies and procedures, and applicable laws, regulations and standards.

- Original medical records may **not** be removed from the HHA's premises **except** by authorization of the patient in a manner consistent with HIPAA regulations, or in response to any other applicable laws or regulations, subpoenas or court orders, and **only** with the express knowledge and approval of the Administrator or his/her designee.

- Medical records of adult patients shall be retained for a minimum of five (5) years after the discharge of the patient or according to state law, whichever is longer. This includes OASIS information. Clinical records must be retained even if the HHA ceases operations.

- Clinical records of minors shall be retained for at least five (5) years following the age of majority, or according to state law.

- Final Validation Reports from OASIS and quality data reporting shall be retained for a period of_____months, per organizational policy.

- Discharged records that have been retained for the appropriate length of time as above, shall be destroyed in a manner that ensures compliance with HIPAA regulations.

- _____ HHA shall retain a patient's medical record for five (5) years after the discharge of the patient unless State law stipulates a longer period of time.

- Clinical and health insurance records are stored electronically via_____. This includes the storage of OASIS information.

- All material shall be available for review by CMS, the intermediary, Department of Health and Human Services, or other specially designated components for bill review, audit or other examination during the retention period.

PROCEDURE:

- All clinical notes, along with patient verification of the visit, shall be completed and submitted to the office within_____hours following completion of the visit.

  - Clinical supervisors shall be responsible for verifying:

    - That all documentation is:

      - Dated
      - Legible
      - Signed appropriately and includes the author's professional designation, i.e., RN, RPT, SLP, CNA
      - Consistent with the ordered and scheduled visit frequency
      - Contains only HHA-approved abbreviations

- That the documentation contains:
  - Complete and accurate patient identification information
  - Supports the diagnosis/patient's clinical status
  - Justifies the care, treatment and/or services provided
  - Describes the care, treatment and/or services provided
  - Describes the results of patient response to the care, treatment and/or services provided
- That the documentation reflects coordination and continuity of care among all team members and reflects accepted and usual standards of practice

 Medical Records Department staff shall be responsible for:

- Maintaining clinical records in the format determined by the HHA
- Ensuring that the content of the records are filed accurately, i.e., in the correct patient's file, and in a timely manner to ensure currency of the record
- Ensuring that Plans of Treatment and physician verbal/telephone orders are signed and returned to the HHA within 30 days of the order initiation date

 The Medical Records Supervisor shall submit a report to the Patient Care Services Director/Administrator every_____of any delinquent documentation, i.e., unsigned physician orders, missing transfer and/or discharge summaries.

- Content of active records shall be filed in each section, with the most recent documentation uppermost; contents of discharged records are to be filed in reverse order.
  - Recommended Format:
    - Section I:
      - Referral/Intake Form
      - Consent/Authorization to Treat Forms
      - Release of Information Forms
    - Section II:
      - Plan of Care
      - Physician Verbal/Telephone Orders
    - Section III:
      - Transfer Forms
      - Discharge Forms
    - Section IV:
      - Nursing Assessment
      - Nursing Visit Notes
      - Summary of Care Notes
    - Section V:
      - Physical Therapy Assessment
      - Physical Therapy Notes
      - Summary of Care Notes

- Section VI:
  - Occupational Therapy Assessment
  - Occupational Therapy Notes
  - Summary of Care Notes
- Section VII:
  - Speech Therapy (SL-P) Assessment
  - Speech Therapy Notes
  - Summary of Care Notes
- Section VIII:
  - Medical Social Work Assessment
  - Medical Social Work Notes
  - Summary of Care Notes
- Section IX:
  - Home Health Aide Notes
  - Home Health Aide Supervisory Visits
- Section X:
  - Miscellaneous, i.e., HHA Notes, Laboratory Test Results

- Access to Paper Medical Records:
  - Any records that are requested by any staff member must be signed for in the Medical Records log.
  - All records must be returned to Medical Records Department before the end of the business day.
- Electronic records may be accessed by authorized staff only.
  - Staff must sign off when they have finished accessing the records in order to prevent unauthorized access to the records.

NOTE:

The Final Validation Reports from submission of OASIS records and quality reporting are not part of the clinical record and, as such, need not be retained for five (5) years. It is recommended that final validation reports be retained for a period of 12 months.

SUBJECT: MEDICAL RECORDS - RETENTION OF FOLLOWING DISCONTINUANCE OF OPERATIONS	REFERENCE #11012
	PAGE: 1
DEPARTMENT: ORGANIZATIONWIDE	OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

To ensure that all patient medical records are retained in accordance with CMS 484.110 should the HHA discontinue operations.

POLICY:

- Should _____ HHA discontinue operations, the Medical Records department, under the supervision of the Administrator, shall submit patient medical records to _____ for custody and retention.

- All patient medical records shall be submitted to the custodian named above prior to the HHA's closing date.

- The HHA shall inform all applicable accrediting agencies, including the State CMS agency, where clinical records will be maintained following the HHA's closure.

SUBJECT: AUDITING OF MEDICAL RECORDS	REFERENCE #11013
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- A sample of patients' medical records shall be reviewed every_____to ensure the HHA's policies are being followed for all services provided including contract services.

- _____ shall review patient medical records, active and closed records.

- The following information shall be reviewed:

  - Required information is present

  - Entries are accurate

  - Entries are legible

  - Entries are authenticated

  - Entries are completed on time

- Any deficiency noted from review of the patient medical record shall be reported to the Clinical Supervisor for follow-up with the appropriate staff member(s).

- Medical record audits shall be tracked and trended for compliance with the HHA's medical records policies. Audit information shall be compiled by_____and reported to the Quality Assessment and Performance Improvement (QAPI) Committee for review and follow-up.

HOME HEALTH MEDICAL RECORDS AUDIT FORM

Patient MR#:_____SOC Date:_____Discharge Date: _____

Review Period: From:_____To: _____

Please comment on any "No" or NA Answers:

	Yes	No	NA	Comments
Admission				
1. Intake/referral form complete				
2. Admission consistent with HHA admission policies				
3. Consent completed, signed and dated				
4. MSP form completed, signed and dated				
5. Medicare/Insurance Card Copy				
6. Acknowledgment of Patient Bill of Rights signed and dated				
7. Advance Directives addressed/present or copy requested				
8. Emergency Management addressed when appropriate				
9. Home Safety addressed				
10. Waste Disposal and Infection Prevention and Control addressed				
11. Actions to take in the event of an emergency addressed				
12. Type and frequency of services to be provided addressed				
13. Informed consent for IV placement signed and dated where applicable				
Plan of Care				
14. Initial Plan of Care signed and dated by physician within _ days				
15. Diagnoses consistent with care ordered				
16. Orders current				
17. Orders appropriate for care to be rendered				
18. Appropriate diagnoses and ICD codes for coverage and reimbursement				

HOME HEALTH MEDICAL RECORDS AUDIT FORM (continued)

Patient MR#:_____SOC Date:_____Discharge Date: _____

Review Period: From:_____To: _____

Please comment on any "No" or NA Answers:

	Yes	No	NA	Comments
19. Medication information complete with dose/ frequency/route, and New or Changed indicated; prn's qualified				
20. Daily skilled nurse visit frequencies with indication of end point				
21. Measurable goals for each discipline with specific time frames				
22. Recertification plan of care signed and dated by physician prior to recertification date				
Change/Verbal Orders				
23. Change/verbal orders include disciplines, goals, frequencies, reason for change, additional supplies as appropriate				
24. Change orders signed and dated by physician within _ days				
Nursing				
25. Assessment includes documentation of:				
a. Nutritional risk assessment				
b. Level of function/mental status				
c. ADL level addressed/caregiver identified				
d. Complete skin assessment/wound description and measurement(s)				
e. Patient Rights and Responsibilities				
f. Advance Directives				
26. OASIS documentation complete and accurate				
27. Assessment packet complete				

HOME HEALTH MEDICAL RECORDS AUDIT FORM (continued)

Patient MR#:_____SOC Date:_____Discharge Date: _____

Review Period: From:_____To: _____

Please comment on any "No" or NA Answers:

	Yes	No	NA	Comments
Medications				
28. Medication Profile consistent with standards/ regulations				
29. Medication Profile updated with changes, initialed and dated				
30. Medication Profile updated at Recertification, initialed and dated				
Nursing Notes				
31. Visit frequencies and duration consistent with physician orders				
32. Orders written for visit frequencies/treatment changes				
33. Homebound status supported on each visit note				
34. Frequency of visits appropriate for patient's needs and interventions provided				
35. Skilled care evident on each note				
36. Evidence of coordination of care				
37. Every note signed and dated				
Aide				
38. Visit frequencies and duration consistent with physician orders				
39. Personal care instructions documented, signed and dated				
40. Personal care instructions modified as appropriate				
41. Notes consistent with personal care instructions and physician orders				
42. Notes reflect supervisor notification of patient complications or changes				

HOME HEALTH MEDICAL RECORDS AUDIT FORM (continued)

Patient MR#:_____SOC Date:_____Discharge Date: _____

Review Period: From:_____To: _____

Please comment on any "No" or NA Answers:

	Yes	No	NA	Comments
43. Visit frequencies appropriate for patient needs				
44. Each note reflects personal care given				
45. Supervisory visits at least every 14 days				
46. Every note signed and dated				
PT/SLP/OP/MSS				
47. Assessment includes evaluation, care plan and visit note				
48. Visit frequencies/duration consistent with physician orders				
49. Evidence of need for therapy/social service				
50. Notes consistent with physician orders				
51. Evidence of skilled service(s) provided in each note				
52. Treatments/services provided consistent with physician orders and care plan				
53. Notes reflect supervisor and physician notification of patient complications or changes				
54. Homebound status validated in each visit note				
55. Notes reflect progress towards goals				
56. Evidence of discharge planning				
57. Evidence of therapy home exercise program				
58. Discharge/transfer summary complete with goals met/unmet				
59. Supervision of PTA/OTA at least every two (2) weeks				
60. Every visit note signed and dated				

HOME HEALTH MEDICAL RECORDS AUDIT FORM (continued)

Patient MR#:_____SOC Date:_____Discharge Date: _____

Review Period: From:_____To: _____

Please comment on any "No" or NA Answers:

	Yes	No	NA	Comments
Miscellaneous				
61. Communication sheets present				
62. Direction sheet present				
63. Medical record in chronological order				
64. Medical record order per HHA policy				
65. Patient name and medical record number (MR#) on every page				
66. Communication with physician regarding test results				

Additional Comments/Recommendations: _____

_____

_____

_____

_____

_____

_____

_____

Name and Title of Reviewer: _____

Signature of Reviewer:_____Date Reviewed:_____

MEDICAL RECORD NUMBER

DEPARTMENT: HOME HEALTH TOPIC: DOCUMENTATION DATE:_____ REVIEWER:_____ CRITERIA																				
A. INTAKE EVALUATION																				
1. Assessed physical environment and risks																				
2. Assessed capability of caregiver to provide care in the home																				
3. Pertinent physical data complete																				
4. Psychological data complete																				
5. Nutritional needs reviewed																				
6. Review of medications																				
B. NURSING NOTES																				
1. Progress of nursing intervention clearly documented																				
2. Record indicates nursing intervention sensitive to circumstances in the home																				
3. Nursing plan of care evident in nursing notes																				
4. Notification of MD within four (4) hours:																				
a. Temp of 100 degrees F oral or 101 degrees F rectal																				
b. Blood Pressure less than 85 or greater than 180 systolic or less than 50 or greater than 110 diastolic																				

MEDICAL RECORD NUMBER

DEPARTMENT: HOME HEALTH TOPIC: DOCUMENTATION DATE:_____ REVIEWER:_____ CRITERIA																				
c. Pulse less than 50, or 45 if patient on beta blocker, or greater than 120																				
d. Significant changes in signs and symptoms																				
e. Abnormal results of diagnostic services																				
f. Appropriate reporting of abuse or neglect																				
g. Lack of family or patient participation																				
C. CARE PLAN																				
1. Goals clearly stated																				
2. Identified needs/problems list includes family																				
3. Evidence of coordination of services																				
4. Client outcomes documented																				
D. PATIENT/FAMILY TEACHING																				
1. Evidence of patient/family teaching																				
2. Evidence of patient/family response to teaching																				

MEDICAL RECORD NUMBER

DEPARTMENT: HOME HEALTH TOPIC: DOCUMENTATION DATE:_____ REVIEWER:_____ CRITERIA																				
E. DOCUMENTATION																				
1. Referral/Face Sheet																				
2. Home Health/DME Order																				
3. Discharge Planning Progress Notes																				
4. Plan of Treatment																				
5. Consent for Treatment and Medical Information Release																				
6. Bill of Rights																				
7. Advance Directives Checklist																				
8. Medication Sheet																				
9. Nurses Care Plan																				
10. Nurses Progress Notes																				
11. Home Health Aide Notes and Personal Care Plan																				
12. PT, OT, MSW Notes																				
13. Lab and X-ray Reports																				
14. Conference Notes																				
15. Discharge Summary																				