

2.3.8 Health Record Documentation, Analysis, and Completion

(a) Policy

California Correctional Health Care Services (CCHCS) shall ensure all health record documentation meets federal and state legal, regulatory, and accreditation requirements. Health Information Management (HIM) and Health Records shall implement systems and processes for quality control and analysis; documents must be complete in order to provide the information necessary for timely continuity of care and patient safety.

(b) Purpose

To ensure HIM staff adheres to federal and state legal, regulatory, and accreditation requirements. These requirements shall encompass systems that will allow for analytical and statistical retrieval of data.

(c) Policy Responsibility

- (1) Under the direction of the Deputy Director, Medical Services, HIM Headquarters, Institution Health Records, and Health Records Center (HRC) staff are responsible for the oversight, implementation, monitoring, and evaluation of this policy.
- (2) The Chief Executive Officer (CEO), or designee, Health Records Technician III (HRT III), and Health Records Technician II (HRT II) of each institution are responsible for the implementation, monitoring, and evaluation of this policy.

(d) Procedure Overview

To ensure HIM staff adhere to state and federal legal, regulatory, and accreditation requirements. These requirements must encompass systems that will allow for analytical and statistical retrieval of data.

(e) Procedure Responsibility

- (1) The CEO, or designee, HRT III, and HRT II Supervisor are responsible for ensuring the health record is analyzed for accuracy and completion and is readily accessible for patient care. They are also responsible for ensuring health care documents are in the health record timely.
- (2) Under the direction of the Deputy Director, Medical Services, the Medical Record Directors at headquarters are responsible for the oversight, implementation, monitoring, and evaluation of this procedure through consultation.

(f) Procedure

- (1) HIM staff shall analyze documents in the health record to ensure compliance with the following general documentation guidelines:
 - (A) An individual health record shall be established for every patient who receives care.
 - (B) Content and format of the health record shall be uniform and use only approved California Department of Corrections and Rehabilitation (CDCR) forms.
 - (C) For patient safety reasons, abbreviations, acronyms, and symbols shall be used only when their meanings are understood and they are on the CCHCS approved list of abbreviations and symbols.
 - (D) All entries shall be legible.
 - (E) The patient's name and CDCR number shall appear on every individual paper document that contains Protected Health Information (PHI). The patient demographic information shall appear on every screen in the health record.
 - (F) Documentation shall be clear, concise, objective, reflect factual information, and be written using specific language. Avoid using vague or generalized language. Remarks critical to the care or services provided by others shall not be included in the health record.
 - (G) Clinicians shall indicate that they have reviewed diagnostic reports by initialing and dating each report. A plan of care that addresses any abnormal test results shall be documented in the health record.
 - (H) All verbal consents for health care procedures shall be documented, and the originals of signed consent forms shall be placed/scanned in the health record.
 - (I) All health record entries must be authenticated and include the date (month, day, and year), time, and signature or initials and credentials of the author.
 - (J) All patient encounters shall be documented in the health record including all patient education and validation that effective communication was provided and appropriately documented.
 - (K) In addition to the handwritten signature, the clinician may use a personal rubber stamp which contains the clinician's name and title for increased legibility.
- (2) Any author documenting in the health record shall be responsible for the completeness and accuracy of their entries.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

- (3) All clinical documentation errors shall be corrected by the clinician in compliance with federal and state statutes and regulations.
- (4) All amended documents shall be scanned into the health record.
 - (A) Request for amendments are received by the HIM Department.
 - (B) HIM staff shall:
 1. Log each request into the Patient Access Log.
 2. Review the request for the type of changes requested.
 3. Conduct a preliminary review of the health record. Compare the original entry with the requested changes.
 - (C) If informational content changes are requested:
 1. Forward the request to the Chief Medical Executive (CME) or Chief of Mental Health as appropriate for review and action.
 2. The CME or Chief of Mental Health and the treating clinician shall confer and review the amendment request.
 3. If request for amendment is approved, clinicians shall follow Section (f)(4)(D) below.
 4. If request for amendment is not approved, clinicians shall follow Section (f)(4)(E) below.
 5. HIM staff shall scan all patient requests for amendment into the Medico-Legal section of the health record upon receipt from the clinician.
 - (D) To process amendment requests:
 1. The original entry shall not be obliterated or deleted.
 2. Enter the amended information into the health record.
 3. Make a notation at the point of the original entry, in the margin or by attaching a note to the entry, that an amendment notice has been made and reference the amended information.
 4. Record the reason for the amendment or refer to the patient's written request.
 5. Document the statement of facts.
 6. Date and time the amendment using the 24-hour clock.
 7. Sign the amendment with full name and title.
 8. Identify the location of any secondary records that substantiate the amendment.
 - (E) Respond in writing to the patient if the request is denied:
 1. Indicate action taken, e.g., "amendment notice filed this date."
 2. Attach a copy of the response to the written request and forward to HIM to incorporate into the patient's health record.
 - (F) Include any amendments or requests for amendments in all subsequent releases of health information requests.
- (5) An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident.

References

- California Code of Regulations, Title 22, Division 5, Chapter 9, Article 4, Section 77139, Health Record Service; Section 77141, Health Record Content; and Section 77143, Health Record Availability
- American Health Information Management Association (AHIMA):
 - *Health Information Management Concepts, Principles, and Practice*, Chapter 3, Documentation Standards, Pages 91-93; Chapter 8, Paper-based and Hybrid Health Records, and Incomplete Record Control, Pages 212-215 (Third ed., 2010)
 - *Documentation for Ambulatory Care*, General Documentation Guidelines (Revised ed., 2001)
 - *Update: Maintaining a Legally Sound Health Record – Paper and Electronic*, Journal of AHIMA 76, No. 10, 64A-L (Nov-Dec 2005)

Revision History

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