Upon completion of this lesson, students should be able to:

1. Define and spell the terms to learn for this chapter.
2. Discuss ownership of the medical record.
3. Discuss the problem-oriented medical record.
Upon completion of this lesson, students should be able to:

4. Describe the four sections of the SOAP charting method.
5. Name and state the purpose of each component of the medical record.
6. List the steps involved in collating medical records.
Purpose and Ownership of the Medical Record

- Medical record is a:
  - Legal document
  - Permanent record
  - Tool used by staff members to communicate within their office and other offices regarding services delivered to the patient
Purpose and Ownership of the Medical Record

- HIPAA
  - Patient owns information in medical record and has the right to control under what circumstances, and with whom, it is shared
Standard Medical Record and Types of Reports Found in the Record

- Patient's past medical records
- History and physical
- Insurance information
- Office notes
- Progress notes
- Telephone messages
- Pathology results
- Nursing notes
Standard Medical Record and Types of Reports Found in the Record

- Medications
- Physician orders
- Radiology reports
- Laboratory reports
- Operative reports
- Consultation reports
- ECGs
- Miscellaneous
Purpose and Ownership of the Medical Record

- The Medical Record as a Legal Document
  - Entries in medical records written in black ink
  - Documentation factual, based on statements of patient and physician's assessment
Lesson Objectives

Purpose and Ownership of the Medical Record

- The Medical Record as a Legal Document
  - If you make an error, do not erase or totally obliterate original error with products
  - Draw single line through error so original entry can be seen, enter your initials and date above single line, and word "Error"
Purpose and Ownership of the Medical Record

Ownership of the Medical Record

- Patients own the information in their medical records
- Facility that created information owns physical or electronic record
- Patients have the right to view their medical records
- Staff member present when a patient reviews the record
Purpose and Ownership of the Medical Record

- Ownership of the Medical Record
  - Original radiology image property of medical facility that performed the X-ray
  - HIPAA requires covered entities follow privacy and security rules for protected health information (PHI)
Purpose and Ownership of the Medical Record

• Ownership of the Medical Record
  • Loss of medical records a serious problem, and staff involved must take required legal and ethical action of reporting it
Purpose and Ownership of the Medical Record

• Releasing Medical Records
  • Notice of Privacy Practices (NPP)
  • Consent to the use and disclosure of PHI for treatment, payment, operations as defined by HIPAA
Purpose and Ownership of the Medical Record

• Releasing Medical Records
  • Patients must explicitly authorize release of their records in writing as well as:
    • Parents of minor children
    • Legal guardian
    • Agent
Purpose and Ownership of the Medical Record

• Releasing Medical Records
  • Federal law provides special protection for substance abuse treatment records
  • Some state laws for HIV/AIDS information and mental health records
  • Although medical records are confidential, at times they can be released without a patient's explicit authorization
Purpose and Ownership of the Medical Record

• The Role of the Medical Assistant
  • Legibility
  • Accuracy
  • Timeliness
  • Accessibility
Documentation Formats

• Common Documentation Formats
  • Chronological medical record
  • Problem-oriented medical record
  • SOAP charting
  • Source-oriented medical record
Documentation Formats

- Chronological Record
  - Follows the patient over a period of time
  - Each visit consists of a new entry by date rather than by symptom or diagnosis
  - One of the most common types of medical records
  - This record makes it difficult to track diagnoses through multiple visits
Documentation Formats

- Problem-Oriented Medical Record (POMR)
  - Developed by Dr. Lawrence Weed in 1970
  - Identifies patient problems and organizes chart by those problems
  - Functional aspect is patient problem list found at front of the chart
Documentation Formats

• Problem-Oriented Medical Record (POMR)
  • As new problems and diagnoses identified, they are noted on the problem list, helping health care provider to identify trends
Documentation Formats

- Problem-Oriented Medical Record (POMR)
  - Database
  - Problem list
  - Plan
  - Progress notes
Documentation Formats

- SOAP Charting
  - Organizes progress notes in documentation of encounter into four distinct parts
    - Subjective
    - Objective
    - Assessment
    - Plan
**FIGURE 13-4** An example of SOAP charting.

<table>
<thead>
<tr>
<th>Date</th>
<th>Problem Number</th>
<th>S = Subjective</th>
<th>O = Objective</th>
<th>A = Assessment</th>
<th>P = Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/12/06</td>
<td>1</td>
<td>&quot;I'm having dizzy spells and have not been taking my BP med.&quot;</td>
<td>BP 170/110 both arms, lying down, sitting &amp; standing; WT. 202#</td>
<td>Hypertension</td>
<td>Rx for Norvasc 5mg daily; to monitor BP and return in 1 week for BP check; placed on 1200 calorie diet to lose 20#</td>
</tr>
</tbody>
</table>
Documentation Formats

- SOAP Charting
  - POMR and SOAP methods can be combined in one chart, making for a very concise, clear set of information on any patient.
Documentation Formats

- Source-Oriented Medical Record (SOMR)
  - Commonly used in medical clinics
  - Patient information organized in sections for various purposes
  - Maintained in reverse chronological order with most recent information seen first
Documentation Formats

• Source-Oriented Medical Record (SOMR)
  • With this method, it can be more complicated to identify and locate past medical problems, treatments, and results
Critical Thinking Question

1. What types of information should be included in the patient chart, and why?
Components of the Medical Record

- Patient registration
- Family and medical history
- Physical examination results
- Test results
- Records from other physicians and hospital visits
- Informed consent forms
- Diagnosis and treatment plan
Components of the Medical Record

- Patient correspondence; follow-up care
- Consultation report
- Operative report
- Pathology report
- Radiology report
- Discharge summary
- Additional reports
- Medical transcription
Organizing a Patient’s Medical Record

• Verify you have correct patient record for patient documents you have been given.
• File documents in chronological order in the correct areas of the file, according to your facility policy, for consistency.
• Return medical record to correct place in alphabetic or numeric order with other patient files.
Collating Medical Records

- Collating: process of gathering and organizing information
  - Print or copy day's appointment schedule.
  - Pull all medical records of patients scheduled to be seen.
  - In each record, review patient's last appointment and make note of any results that should have been received.
Collating Medical Records

• Collating: process of gathering and organizing information
  • If any of the results are not in patient's chart, call appropriate facilities to retrieve results.
  • Make a list of all results that have been received by phone and any that are outstanding.
Collating Medical Records

- Collating: process of gathering and organizing information
  - Add all received information to each chart for the physician to review and sign off on.
Filing, Storage, and Retention of Paper Medical Records

• Active Records
  • Patients who have been seen within past three years and are currently being treated

• Inactive Records
  • Patients who have not been seen within past three years or time period determined by office policy
Filing, Storage, and Retention of Paper Medical Records

• Closed Records
  • Patients who have actively terminated their contact with the physician
Filing, Storage, and Retention of Paper Medical Records

- File Storage
  - Vertical
  - Lateral
  - Movable
Filing, Storage, and Retention of Paper Medical Records

- Color-Coded Label Systems
  - Decreases number of misfiled charts
  - Aids in file retrieval
  - Assigns unique color for each number from 0 to 9 and for each letter A to Z
  - Colored bands on each label visible when files are shelved
  - When files are correctly placed, colored bands all have the same pattern
Filing, Storage, and Retention of Paper Medical Records

- Color-Coded Label Systems
  - Ames Color File System
  - Smead Manufacturing Company's
  - Alpha-Z Alphabetic Color-Coding System
A color-coded record.
Filing, Storage, and Retention of Paper Medical Records

• Rules for Filing
  • Key to alphabetic filing is to divide names and titles into units
  • Numeric filing (patient identification system): used in hospitals and larger clinics; number assigned to each patient's medical record
  • Simplest numeric method is straight numeric filing system
Filing, Storage, and Retention of Paper Medical Records

• Rules for Filing
  • Terminal-digit filing, based on last two digits of ID number, evenly distributes files within entire filing system
  • Using same six-digit numbering system as terminal-digit system, middle-digit filing system places middle digits as primary numbers
Filing, Storage, and Retention of Paper Medical Records

- Rules for Filing
  - Unit-number filing system used by hospitals; number assigned to patients first time they are seen or admitted to a hospital
  - Serial-number filing system, patient receives a different medical record number for each hospital visit
  - Filing by subject matter used for general files
Filing, Storage, and Retention of Paper Medical Records

• Rules for Filing
  • Cross-referencing: alerting health worker a file may be found under another name.
  • When a file cannot be located, it is important to conduct a thorough search of the office.
Filing, Storage, and Retention of Paper Medical Records

• Rules for Filing
  • Essential missing file be located as soon as possible and returned to its proper location.
  • Ability to locate files quickly is an indicator of quality assurance.
Filing, Storage, and Retention of Paper Medical Records

• Locating Missing Files
  • Begin by looking for a file with sound-alike or look-alike name.
  • If patient has a first name that might be considered as a last name, look in section where you would find the first name.
Filing, Storage, and Retention of Paper Medical Records

• Locating Missing Files
  • If using color-coding, look for a folder that is out of place based on color-coded label.
  • If using a numeric system, look for a transposition of numbers.
Filing, Storage, and Retention of Paper Medical Records

- Locating Missing Files
  - Look for transposition of letters.
  - Look for alternative spelling.
  - Look at folders filed before and after missing record.
  - Look on physician's desk and through in and out baskets.
  - Ask others in office to assist you.
Filing, Storage, and Retention of Paper Medical Records

• Rules for Filing
  • Tickler file used to remind medical assistants of event or action that will take place at a future date.
  • Tickler files can be in a file drawer or an index card tickler file.
Retention of Medical Records

• To be absolutely safe, all medical records should be retained forever.
• Medical record is critical in a medical liability action.
• Its loss may considerably harm the physician in the defense of a claim.
• At a minimum, retain records until statute of limitations expires.
Retention of Medical Records

• Each state varies on legal time limits to keep records and documents.
• In many cases, statute of limitations is two years.
• Special rules apply when treating a child or an incompetent patient, in which case the time period is longer.
Retention of Medical Records

- Most states require all patient records be retained for two to seven years after the last treatment OR
- Seven years after patient reaches age of majority (18 or 21), whichever comes last.
- American Medical Association recommends keeping medical records for ten years.
Retention of Medical Records

• In selected circumstances, consider saving more complex records or those records with known serious patient problems for a longer period of time.
• Keep immunization records as long as practical; patients may need to access them at a future date.
Lesson Objectives

Destruction of Medical Records

• Medical record destruction policy should follow a written procedure.
• Outline length of time records will be kept.
• Define which records will be kept on-site and which off-site.
• Designate a person to be responsible for deciding what to keep and what to purge.
Lesson Objectives

Destruction of Medical Records

- Produce a log that details which patient records have been destroyed, as well as why, when, and how.
- Provide method of disposal (shred, pulp, or incinerate) that destroys all information in the record.
Lesson Objectives

Destruction of Medical Records

• Patient confidentiality cannot be jeopardized because of inadequate method of destruction.
• Many medical offices hire services of a business that handles destruction of medical records.
• That service must agree to abide by HIPAA guidelines.