MEDICAL RECORD SERVICES

Self-Assessment Questions	YES	NO	N/A	Date / Initials	Comments
ORGANIZATION					
Does your Medical Record Service have a system that assures: a. timely processing of records? b. coding/indexing of the record system that protects the confidentiality of medical information? c. compiling and retrieval of data and quality assurance activities? d. authentication and security of patient records? e. assuring patients direct access to his/her entire medical record except for information reasonably likely to cause substantial harm to the individual or another person as determined by the patient's physician and the patient's representative? f. a written authorization of the patient or legal representative is required for access to, or for the release of information, copies or excerpts to persons not otherwise permitted to receive this information? g. electronic patient records is controlled access through standard measures, such as business rules defining access, passwords, etc.? h. medical records may only be removed from the hospital premises by court order, subpoena, or Federal or State laws? i. electronic records are stored by a mechanism that prevents the loss of part or all of the record from the medical record system? j. completion of records demonstrated by randomly sampling patient charts for review? k. circumstances in which incomplete medical records may be closed? A-0432 COP §482.24(a)(b) A-0438 COP §482.24(b) A-0441 COP §482.24(b)(3) A-0148 COP §482.13(d)(2) RSMo 191.227	❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑		
Does your hospital have policies in place that defines the process for limiting the disclosure of a patient's medical record with and without permission? A-0441 COP §482.24(b)(3)	❑	❑	❑		

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STAFF					
Do you employ adequate personnel to ensure prompt completion, filing and retrieval of records as demonstrated by staffing schedules? A-0432 COP §482.24(a)	❑	❑	❑		
RECORD RETENTION					
Are records maintained: a. for all inpatient and outpatient encounters? b. so that inpatient and outpatient records can be cross-referenced? c. at least 10 years for adults? d. until a minor reaches his/her 20th birthday or 10 years whichever occurs later? e. in their original or legally reproduced form in hard copy, microfilm, computer memory or electronic storage media? f. so as to safeguard them against unauthorized access, loss, theft, defacement, tampering, reproduction and damage from fire and/or water? g. according to hospital policy that ensures that the "original" medical records are retained unless their release is mandated by Federal or State law, court order or subpoena? A-0438 COP §482.24(b) A-0439 COP §482.24(b)(1) A-441 COP §482.24(b)(3) 19 CSR 30-20.015(17)	❑ ❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑ ❑		
Can records be quickly retrieved by diagnosis and procedure? A-0440 COP §482.24(b)(2)	❑	❑	❑		
Are precautions taken to ensure the accuracy and security of all patient records? A-0438 COP §482.24(b)	❑	❑	❑		
Can you demonstrate through a random chart audit the precautions that are in place to prevent physical or electronic altering of content previously recorded in the medical record? A-0441 COP §482.24(b)(3)	❑	❑	❑		
Are medical records only disclosed, without a patient's authorization, when related to payment operations and/or health care operations (e.g. QAPI activities, utilization review, audits,	❑	❑	❑		

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competency assessment, etc.)? A-0441 COP §482.24(b)(3)					
Can you demonstrate, through written proof from the patient, approval for release or access to their health information for anyone not otherwise authorized to receive this information? 19 CSR 30-20.94(5) A-0441 COP §482.24(b)(3)	❑	❑	❑		
RECORD CONTENT					
Are all entries in the medical record: a. legible and complete? b. only made by individuals specified in hospital and medical staff policies? c. timed, dated and authenticated by name and discipline by the individual responsible for ordering, providing or evaluating the service furnished? A-0450 COP §482.24(c) A-0450 COP §482.24(c)(1)	❑ ❑ ❑	❑ ❑ ❑	❑ ❑ ❑		
Does your hospital specify the methods by which medical records may be authenticated? A-0450 COP §482.24(c)(1) Note: Medical records maybe authenticated by signatures initials; reviewing documents on-line and entering a computer code; reviewing individual records then signing off against a list of entries; a mail system in which transcripts are sent to the physician for review and he/she signs and returns a postcard identifying the record and verifying its accuracy; and rubber stamps.	❑	❑	❑		
If rubber (signature) stamps are permitted: a. does the hospital have a statement signed by the practitioner that he/she is the only one who has and uses the stamp? b. is the statement kept in administration along with a copy in medical records? A-0450 COP §482.24(c)(1)	❑ ❑	❑ ❑	❑ ❑		
Can you verify that rubber (signature) stamps only are used by the practitioner who has that signature and that its use is not delegated to anyone else? A-0450 COP §482.24(c)(1)	❑	❑	❑		

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If computer or other codes are used, are the codes and written signatures readily available and maintained under adequate safeguards? A-0450 COP §482.24(c)(1)	❑	❑	❑		
When parts of the medical record which are the responsibility of the physician are delegated to a non-physician, are they reviewed, dated and authenticated by the responsible physician within the required time period? A-0450 COP §482.24(c)(1)	❑	❑	❑		
Can you verify that physicians do not authenticate reports before transcription? A-0450 COP §482.24(c)(1)	❑	❑	❑		
Do all medical records contain the following: a. admitting diagnosis? b. results of all consultative evaluations and appropriate findings by clinical and other staff involved in the patients care? c. reports of complications, healthcare-associated infections and unfavorable reactions to drugs and anesthesia? d. history and physical including family history, completed by a physician , an oromaxillofacial surgeon, or other qualified individual in accordance with state law and hospital policy no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia except in cases of emergency or according to hospital policy? e. documentation of an updated examination being done within 24 hours of admission or prior to surgery/procedure requiring anesthesia, including any changes in the patient's condition, if the H&P was completed within 30 days or according to hospital policy? f. a history and physical placed in the medical record within 24 hours after admission and registration but prior to surgery or procedure requiring anesthesia services, except in the care of emergencies? g. an assessment completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services,	 ❑ ❑ ❑ ❑ ❑ ❑	 ❑ ❑ ❑ ❑ ❑ ❑	 ❑ ❑ ❑ ❑ ❑ ❑		

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when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services?					
h. practitioners' orders and progress notes, nursing notes, treatment reports, medication records, (if applicable, radiology, laboratory, ECGs, surgical procedures, therapy, anesthesia, pathology and autopsy reports), vital signs and other information necessary to monitor the patient's condition, justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services?	❑	❑	❑		
i. discharge summary with outcome of hospitalization, disposition and provisions for follow-up care?	❑	❑	❑		
j. final diagnosis with completion of medical records within 30 days of discharge?	❑	❑	❑		
A-0463 COP §482.13(c)(4)(ii) A-0464 COP §482.24(c)(4)(iii) A-0465 COP §482.24(c)(4)(iv) A-0458 COP §482.24(c)(4)(i)(A) A-0461 COP §482.24(c)(4)(i)(B) A-0462 COP §482.24(c)(4)(i)(C) A-0467 COP §482.24(c)(4)(vi) A-0468 COP §482.24(c)(4)(vii) A-0469 COP §482.24(c)(4)(viii)					
ORDERS					
If preprinted order sets are used,					
a. does the practitioner sign, date, and time the last page of the orders?	❑	❑	❑		
b. does the last page also identify the total number of pages in the order set?	❑	❑	❑		
c. are any changes (additions, deletions, or strike outs) initialed/signed at the bottom of that page and where the specific change is made?	❑	❑	❑		
If a pre-established electronic order set is used, does the practitioner sign, date and time the final	❑	❑	❑		

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order that contains all the selections made? A-0450 COP §482.24(c)(1)					
Are all orders, including verbal orders, received dated, timed and authenticated by the receiver according to hospital policy? A-0454 COP §482.24(c)(2)	❑	❑	❑		
Is the verbal order promptly authenticated, dated and timed by the prescribing practitioner or other practitioner responsible for the patient's care in accordance with the hospital policies and medical staff bylaws and scope of practice? A-0454 COP §482.24(c)(2)	❑	❑	❑		
If the verbal order is authenticated, dated and timed by a practitioner other than the prescribing practitioner, does the prescribing practitioner also sign the verbal order within a time frame established by the hospital? A-454 COP §482.24(c)(2)	❑	❑	❑		
Are your pre-printed and electronic standing orders, order sets, and protocols: a. approved by medical staff, nursing, and pharmacy? b. aligned and consistent with nationally recognized and evidence-based guidelines? c. reviewed and revised regularly, at a minimum annually, to determine continued usefulness by medical staff, nursing, and pharmacy? d. dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient only if such practitioner is acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules and regulations? A-0457 COP §482.24(c)(3)	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑		
Can you demonstrate that standing orders are not used for restraints or seclusion? A-0457 COP §482.24(c)(3)	❑	❑	❑		
If your facility utilizes standing orders: a. are policies and procedures in place to address the process by which a standing	❑	❑	❑		

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order is developed, approved, monitored, initiated by authorized staff, and subsequently authenticated by physicians or other practitioners responsible for the patient's care?					
b. do they contain specific criteria for which a nurse or other authorized person can initiate a particular standing order?	❑	❑	❑		
c. do policies and procedures address training and education of staff regarding when and how to initiate standing orders?	❑	❑	❑		
d. is the order added to the chart as soon as possible at the time or shortly thereafter initiation?	❑	❑	❑		
e. does the practitioner responsible for the care of the patient acknowledges and authenticates the initiation of all standing orders?	❑	❑	❑		
Note: Influenza and pneumococcal vaccines are exempt. A-0457 §482.24(c)(3)					
INFORMED CONSENT					
Does the medical record also include properly executed informed consent forms for procedures and treatments as specified by the medical staff, or by Federal or state law? A-0466 COP §482.24(c)(4)(v)	❑	❑	❑		
At a minimum, does the informed consent contain:					
a. name of hospital where the procedure or other type of medical treatment is to take place?	❑	❑	❑		
b. name of the specific procedure, or other type of medical treatment for which consent is being given?	❑	❑	❑		
c. name of the responsible practitioner who is performing the procedure or administering the medical treatment?	❑	❑	❑		
d. state that the procedure or treatment, including the anticipated benefits, *material risks, and alternative therapies, was explained to the patient or the patient's legal representative?	❑	❑	❑		

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Note: *Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity. Hospital are free to delegate to the responsible practitioner, who uses the available clinical evidence as informed by the practitioner's professional judgment, the determination of which material risks, benefits and alternatives will be discussed with the patient. e. signature of the patient or the patient's legal representative? f. date and time the informed consent form is signed by the patient or patient's representative? A-0466 COP §482.24(c)(4)(v) Note: All see A-0466 Interpretive Guidelines for additional recommendations for informed consent, surgical services section and COP §482.51(b)(2).	❑ ❑	❑ ❑	❑ ❑		
Does the medical record of decreased patients contain the: a. date and time of death? b. autopsy permit, if granted? c. disposition of body, by whom received and when? 19 CSR 30-20.015(15)	❑ ❑ ❑	❑ ❑ ❑	❑ ❑ ❑		

Key Resources and Links

- COP §482.57
- COP §482.24
- COP §482.51