CRITICAL ACCESS HOSPITALS

CLINICAL RECORDS

Self-Assessment Questions	YES	NO	N/A	Date/Initials	Comments
Does CAH have a system with written, current policies and procedures that assures:					
a. a medical record for each person receiving care at CAH?	❑	❑	❑		
b. storage in a secure location with protection from damage such as flood or fire?	❑	❑	❑		
c. storage in secure location with access to only authorized individuals?	❑	❑	❑		
d. timely processing, easy retrieval, readily accessible medical records?	❑	❑	❑		
e. confidentiality of medical information?	❑	❑	❑		
f. compiling and retrieval of data for quality assurance activities?	❑	❑	❑		
g. Integrity and security of patient records?	❑	❑	❑		
h. 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 or practitioner?	❑	❑	❑		
i. the use of authentication systems including appropriate sanctions for the unauthorized or improper use of computer codes?	❑	❑	❑		
j. that a written consent of the patient or legal representative, person with appropriate power of attorney to act on the patient's behalf is required for access to, or for the release of information, copies of medical records?	❑	❑	❑		
k. that medical records may only be released to authorized individual or by court order, subpoena?	❑	❑	❑		
l. patient records are not left unsecured or unattended in hallways, patient rooms, nurse's stations printers, other non-secured areas etc.?	❑	❑	❑		
m. prompt completion of medical records	❑	❑	❑		
n. only authorized persons are permitted access to records?	❑	❑	❑		
o. is accessible to authorized staff 24/7 as may be needed?	❑	❑	❑		
C-1102 COP §485.638(a)(1) C-1118 COP §485.638(a)(4)(iv) C-1120 COP §485.638(b)(1) C-1122 COP §485.638(b)(2) C-1124 COP §485.638(b)(3)					
Does the CAH employ adequate qualified personnel to ensure prompt completion, filing and	❑	❑	❑		

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Self-Assessment Questions	YES	NO	N/A	Date/Initials	Comments
retrieval of records as demonstrated by staffing schedules? C-1102 COP §485.638(a)(1)					
Is the designated member of the professional staff responsible for maintaining records: a. have adequate personnel to keep the records safe, organized and accessible? b. appointed by the governing body or authorized representative? c. responsible for all inpatient and outpatient records? C-1106 COP §485.638(a)(3)	❑ ❑ ❑	❑ ❑ ❑	❑ ❑ ❑		
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 or until a minor reaches his/her 20th birthday or 10 years whichever occurs later? (19 CSR 30-20.015(17)) Note: CoPs specify a minimum of six years. d. in their original form or legally reproducible form such as microfilm or electronic? e. in a manner to safeguard them against loss, defacement, tampering, altering, unauthorized access and damage from fire water, theft etc? C-1102 COP §485.638(a)(1) C-1126 COP §485.638(c) 19 CSR 30-20.015(17)	❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑		
Are medical records only released for patient care evaluation, utilization review, treatment, quality assurance, in-house educational purposes or as dictated federal or state law or by CAH policy? C-1120 COP §485.638(b)(1)	❑	❑	❑		
Does the CAH : a. specify the methods by which medical records may be authenticated? b. maintain a current list of authenticated signatures, written initials and computer codes for authentication verification? c. have sanction in place for unauthorized or improper use of computer code signatures? d. the appropriate policies and procedures in place to implement appropriate authentication methods? C-1118 COP §485.638(a)(4)(iv)	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑	❑ ❑ ❑ ❑		

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When parts of the medical record which are the responsibility of the physician are delegated to a non-physician, are they reviewed, timed, dated and authenticated by the responsible physician as defined in medical staff rules and regulations and as required by State law? C-1118 COP §485.638(a)(4)(iv)	❑	❑	❑		
Do all medical records contain the following: a. complete information regarding medical history, assessment of health status, and health care needs? b. brief summary of each episode, disposition and patient instructions? c. reports of consultation, complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia? d. properly executed consent forms for procedures and treatments specified by the medical staff or federal or state law requiring written patient consent? Note: Properly executed consent forms include the name and signature of patient or legal guardian if appropriate, CAH name, procedure, practitioner(s), performing procedure, date and time consent obtained, statement that procedure was explained to patient or guardian and signature of the professional person witnessing the consent and name/signature of person who explained the procedure to the patient or guardian. e. history and physical completed by a physician (or delegated to other practitioners and reviewed, signed and approved by the physician)? f. timed and dated and authenticated practitioners' orders and progress notes, nursing notes, all treatment reports, medication records, (if applicable, radiology, laboratory, , surgical procedures, therapy, anesthesia, pathology and autopsy reports) all 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 treatments ?	❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑		

CLINICAL RECORDS

Self-Assessment Questions	YES	NO	N/A	Date/Initials	Comments
g. discharge summary with outcome of hospitalization, disposition of patient and provisions for follow-up care? h. final diagnosis with completion of medical records within hospital defined time frames? i. Are records and all entries legible? C-1104 COP §485.638(a)(2) C-1110 COP §485.638(a)(4) C-1114 COP §485.638(a)(4)(ii) C-1116 COP §485.638(a)(4)(i-1118 COP §485.638(a)(4)(iv)	❑ ❑ ❑	❑ ❑ ❑	❑ ❑ ❑		
MISSOURI STATE SPECIFIC REGULATIONS					
Is a certificate each child born alive prepared by the physician or other person in attendance and forwarded to the local registrar within five days after delivery date? (If the physician or other person in attendance does not complete within five days, the person in charge of the institution may complete and sign the certificate.) See also 19 CSR 10-10.040 Filing a Certificate of Live Birth. 19 CSR 30-20.015(13)	❑	❑	❑		
For each dead fetus that is delivered, is a certificate prepared by the person in charge of the institution or his/her designated representative and forwarded to the local registrar within seven days after delivery? See also 19 CSR 10-10.060 Report of Fetal Death. 19 CSR 30-20.015(14)	❑	❑	❑		
Does the medical record contain evidence that the mother was given options for the disposition of the fetal remains in accordance with 194.384 RSMo?	❑	❑	❑		
Do medical records of deceased patients contain the date and time of death, autopsy permit if granted, disposition of the body by whom and when? 19 CSR 30-20.015(15)	❑	❑	❑		
Is the state anatomical board notified of unclaimed dead bodies and a record of this notification maintained? 19 CSR 30-20.015(16)	❑	❑	❑		

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Self-Assessment Questions	**YES**	**NO**	**N/A**	**Date/Initials**	**Comments**

Key Resources and Links

- CMS Conditions of Participation and Interpretative Guidelines
- CMS CAH Page (including crosswalk)
- CMS CAH Basic Training
- Missouri State Hospital Licensing Regulations
- Additional HIM requirements are under Provision of Services and Surgical Services
- CAH may wish to review Acute Hospital Guidelines (SOM Appendix A)for HIM guidance on time frames related to medical record entries and completion