Patient Clinical Records

Home Health and Hospice will establish and maintain a separate clinical record for every patient receiving Home Health and/or Hospice service. The clinical records will be assembled in a systematic fashion allowing for easy access to this information by the Home Health staff. The Secretary will establish and maintain the patient records. The Secretary and trained staff members will file all documentation in the patient record every week according to a standardized format (see Sample Chart).

Only Agency staff members will have access to the patient clinical records. Information from the patient clinical records will only be disclosed as described in the Authorization for Treatment Acknowledgment of Rights and Responsibilities form, unless the patient gives consent or in response to a valid subpoena or court order. The requesting party will reimburse Home Health and Hospice for the usual and customary charges incurred in copying the records. Agency staff members may copy parts of the patient's clinical record as needed for the deliver of their care. Consent for release of medical records applies after the patient's death. Only those persons with legal authority to request copies of the patient's medical record may do so. This includes persons who may be the trustee or executor of that person's will but not someone who had power of attorney prior to that person's death. The power of attorney only applies while the person is alive.

The clinical records will be stored in a lockable filing cabinet, protected by staff members from any unauthorized access. In addition, laptop computers and workstations will be password protected, each employee with their own password. If the laptop or workstation is not in use, the employee will log out of the program to ensure patient confidentiality. In the event that an employee, who has authorization to access any portion of computer leaves employment, their password will be deleted from the database to prevent unauthorized access of patient or Agency information. In the event of a possible security breach, a new password will be assigned to any or all appropriate employees. The Fiscal Manager will maintain the master password list, assign or delete passwords as needed. The Office Manager and Secretary will have knowledge of and be able to access the master password list if needed in absence of the Fiscal Manager. In the event of destruction of the clinical records, constant data may be retrieved from the information management system. Constant data includes:

1. Basic demographic information.
2. Most current HCFA–485 information.
3. Interim orders pertaining to the schedule.

Entries will be made, signed and dated by the person providing care to the patient or patient's family on the appropriate forms. The documentation in the clinical record will be accurate and reflect the physical condition of the patient, the psychosocial status of the patient and family, and the care provided from admission through discharge. All pertinent information about the patient and the patient's family will be filed in the clinical record.

Each patient's clinical record will contain at least, but not limited to, the following:

1. HCFA–485 form.
2. Initial and subsequential assessments by all disciplines.
3. Authorization for treatment and acknowledgment of rights.
4. Release of information form.
5. Identification data.
6. Pertinent medical history.
7. Home Health Aide assignment sheet.
8. Complete documentation of services and events, including, but not limited to, evaluations, treatments and progress
9. Interim orders.
10. Laboratory result sheets.
11. Discharge summaries.
12. Med flow sheet.
13. Progress notes.
14. 60-day physician summaries.
15. Advanced directive information.
16. OASIS documents

Sample Ohio Hospice Policy Manual

Richard Schulz

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