

Home Health and Hospice Policy and Procedure Manual

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 subsequent 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

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Group Practice Personnel Policies Manual Courtney Price, PhD,1997 The Compliance Guide to Ethics, Rights, and Responsibilities Sue Dill Calloway,2005 **Hospice Handbook** Lenora Finn Paradis,1985 *Current Catalog* National Library of Medicine (U.S.),1985 First multi year cumulation covers six years 1965 70 Page's Ohio Revised Code Annotated Ohio,1953 **Current Catalog** ,1988 First multi year cumulation covers six years 1965 70 *National Library of Medicine Current Catalog* National Library of Medicine (U.S.),1985 **Quality of Life Technology Handbook** Richard Schulz,2012-10-03 A collaboration between leading scientists practitioners and researchers at Carnegie Mellon University and the University of Pittsburgh this book is a comprehensive resource describing Quality of Life technologies and their development evaluation adoption and commercialization It takes an interdisciplinary team approach to the process of technology development

Ohio Shopper's Guide to Long Term Care Insurance ,1997 **The Handbook of Stress and Health** Cary Cooper,James Campbell Quick,2017-04-17 A comprehensive work that brings together and explores state of the art research on the link between stress and health outcomes Offers the most authoritative resource available discussing a range of stress theories as well as theories on preventative stress management and how to enhance well being Timely given that stress is linked to seven of the ten leading causes of death in developed nations yet paradoxically successful adaptation to stress can enable individuals to flourish Contributors are an international panel of authoritative researchers and practitioners in the various specialty subjects addressed within the work

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