Maintaining a Legally Sound Health Record

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The health record is the legal business record for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. The standards may vary based on practice setting, state statutes, and applicable case law. An attorney should review policies related to legal documentation issues to assure adherence to the most current standards and case law.

HIM professionals should fully understand the principles for maintaining a legally sound health record and the potential ramifications when the record's legal integrity is questioned. This practice brief will review the legal documentation guidelines for entries in and maintenance of the health record. Many of the guidelines originally applied to a paper-based health record; however, the principles can also apply to documentation in an electronic health record.

Admissibility as Evidence in a Legal Proceeding

Generally, statements made outside the court by a party in a lawsuit are considered hearsay and not admissible as evidence. Documentation in the health record is technically hearsay; however, Federal Rules of Evidence (803(6)) and the Uniform Business and Public Records Act adopted by most states allow an exception to the hearsay rule for records maintained in the regular course of business, including health records. Four basic principles that must be met for the health record to be admissible as evidence are:

- the record was documented in the normal course of business (following normal routines)
- the record was kept in the regular course of business
- the record was made at or near the time of the matter recorded
- the record was made by a person within the business with knowledge of the acts, events, conditions, opinions, or diagnoses appearing in it

Computerized health records are also admissible if they meet the four basic principles above and are shown to be accurate and trustworthy. The *Comprehensive Guide to Electronic Health Records* outlines the following facts to support accuracy and trustworthiness:

- the type of computer used and its acceptance as standard and efficient equipment
- the record's method of operation
- the method and circumstances of preparation of the record, including:
  - the sources of information on which it is based
  - the procedures for entering information into and retrieving information from the computer
  - the controls and checks used as well as the tests made to ensure the accuracy and reliability of the record
- the information has not been altered

The rules of evidence provide the legal foundation for many principles related to documentation and securing health records. Entries must be timely and made by an individual who has knowledge of the act, event, or assessment. Records must be secured in a manner that prevents alteration or tampering. When health records become suspect, they can be a liability.

The HIM professional or a designee is often considered the custodian of the health record and may be called to testify to the admissibility of the record. He or she may be asked to verify the timeliness and the normal business practices used to develop and maintain the health record.

Who May Document

Joint Commission standard IM7.1.1 states that only authorized individuals may make entries in the medical record. AHIMA recommends that anyone documenting in the health record should be credentialed or have the authority and right to document as defined by the organization's policy. Individuals must be trained and competent in the fundamental documentation practices of the organization and legal documentation standards. All writers should be trained in and follow their organization's standards and policies for documentation.

Linking Each Entry to the Patient

Every page in the health record or computerized record screen must identify the patient by name and health record number. Patient name and number must be on both sides of every page as well as on every form, computerized printout, etc. Both paper and computer-generated forms with multiple pages must also have the patient name and number on all pages.

Timeliness of Entries

The timeliness of an entry is critical to the admissibility of a health record in court as required by the Uniform Rules of Evidence. Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time events occurred if time is pertinent to the situation.

Date and Time on Entries

Every entry in the health record must include a complete date (including month, day, and year) and a time. Time must be included in all types of narrative notes even if it may not seem important to the type of entry. Charting time as a block (i.e., 7-3) is not advised, especially for narrative notes. Narrative documentation should reflect the actual time the entry was made.

For certain types of flow sheets, such as a treatment record, recording time as a block could be acceptable. For example, a treatment that can be delivered any time during a shift could have a block of time identified on the treatment record with staff signing that they delivered the treatment during that shift. For assessment forms where multiple individuals are completing sections, the date and time of completion should be indicated as well as who has completed each section (exception: standardized data sets such as the MDS and OASIS).

Pre-dating and Back-dating

It is both unethical and illegal to pre-date or back-date an entry. Entries must be dated at the date and time they are made as required by the Rules of Evidence.

Documentation Content

The content of documentation in the health record is the basis for a healthcare organization to defend itself in a legal proceeding and provide evidence of medical treatment delivered. The following guidelines can help ensure that the health record is a reliable source of information:

Specific

Use language that is specific rather than vague or generalized. Do not speculate. The record should always reflect factual information (what is known versus what is thought or presumed) and be written using factual statements. Examples of generalizations/vague words: Patient doing well, appears to be, confused, anxious, status quo, stable, as usual. If an author mustspeculate (i.e., a diagnosis is undetermined), the documentation should clearly identify speculation versus factual information.

Objective

Chart the facts and avoid the use of personal opinions when documenting. By documenting what can be seen, heard, touched, and smelled, entries will be specific and objective. Describe signs and symptoms, use quotation marks when quoting the patient, and document the patient's response to care.

Complete

Document all facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviation from standard treatment (including the reason for it). Make sure the entry is complete and contains all significant information. If the original entry is incomplete, follow guidelines for making a late entry, addendum, or clarification.

Use of Abbreviations

Every healthcare organization should set a standard for acceptable abbreviations to be used in the health record and develop an organization-specific abbreviation list. Only those abbreviations approved by the organization should be used in the health record. When there is more than one meaning for an approved abbreviation, chose one meaning or identify the context in which the abbreviation is to be used.[1]

Legible

All entries in the health record must be legible. Illegible documentation can put the patient at risk. Readable documentation assists other caregivers and helps to ensure continuation of the patient's plan of care. If an entry cannot be read, the author should rewrite the entry on the next available line, define what the entry is for referring back to the original documentation, and legibly rewrite the entry. Example: "Clarified entry of (date)" and rewrite entry, date, and sign. The entry rewritten must be the same as the original.

Continuous Entries

In manual records, document entries on the next available space. Do not skip lines or leave blanks. There must be a continuous flow of information without gaps or extra space between documentation. A new form should not be started until all previous lines are filled. If a new sheet was started, the lines available on the previous page must be crossed off. If an entry is made out of chronological order it should be documented as a late entry.

Complete All Fields

Some of the questions or fields on documentation tools such as assessments, flow sheets, and checklist documents may not be applicable to the patient. All fields should have some entry made whether it applies to the patient or not. If a field is not applicable, an entry like "N/A" should be made to show that the question was reviewed and answered. Fields left blank may be suspect to tampering or back-dating after the document has been completed and authenticated. If the documentation will be reported by exception (e.g., documenting only on shifts where a behavior occurs), there should be a statement on the form indicating how charting will be completed.

Continuity of Entries--Avoid Contradictions

All entries should be consistent with the following:

- concurrent entries
- other parts of the health record including the assessments, care plan, physician's orders, medication, and treatment records, etc.
- other healthcare organizations' documents--incident reports, nursing service shift reports, etc.

Ongoing treatments and conditions (such as feeding tube, ventilator, tracheostomy, catheter, etc.) should be noted as continuing. Avoid repetitive ("copy cat" or "parrot") charting. The current entry should document current observations, outcomes, and progress. If an entry is made that contradicts previous documentation, the new entry should elaborate or explain why there is a contradiction or why there has been a change.

Change in Condition

Every change in a patient's condition or significant patient care issues must be noted and charted until the patient's condition is stabilized or the situation is otherwise resolved. Documentation that provides evidence of follow-through is critical.

Document Informed Consent

Informed consent should be carefully documented whenever applicable. An informed consent entry should include an explanation of the risks and benefits of a treatment or procedure, alternatives to the treatment or procedure, and evidence that the patient or appropriate legal surrogate understands and consents to undergo the treatment or procedure.

Admission/Discharge Notes

The patient's initial admission note and discharge summary should fully and accurately describe the patient's condition at the time of admission and discharge, respectively. Documentation should include the method/mode of arrival/discharge, patient's response to admission/discharge, and physical assessment. When discharging a patient, take special care in documenting patient education when applicable, including instructions for self-care, and that the patient/responsible party demonstrated an understanding of the self-care regimen.

Notification or Communications

If notification to the patient's physician or family is required, or a discussion with the patient's family occurs regarding the care of the patient, all such communication (including attempts at notification) should be charted. Include the time and method of all communications or attempts. The entry should include any orders received or responses, the implementation of such orders, if any, and the patient's response. Messages left on answering machines should be limited to a request to return call and is not considered a valid form of notification.

Delegation

The charge nurse or nurse manager is responsible for ensuring that all entries by nursing assistants or other clinical staff with delegated responsibilities are complete and consistent with the remainder of the record. All entries by nursing assistants should be reviewed by the charge nurse at the end of the shift. The charge nurse is responsible for all delegated nursing acts, as allowed by state/federal requirements, including charting of such care in the patient's health record (i.e., flowsheets).

Incidents

When an incident occurs, document the facts of the occurrence in the progress notes. Do not chart that an incident report has been completed or refer to the report in charting.

Make and Sign Own Entries

Authors must always make and sign their own entries (both manual and computerized records). An author should never make an entry or sign an entry for someone else or vice versa.[2]

Appropriateness of Entries (Relevant to Patient Care)

The health record should only contain documentation that pertains to the direct care of the patient. Charting should be free from emotional feelings, statements that blame, accuse, or compromise other caregivers, the patient, or his or her family. The health record should be a compilation of factual and objective information about the patient. The record should not be used to voice complaints about other caregivers, departments, physicians, or the healthcare organization, family fights, fights between disciplines, gripes, staffing issues, vendor issues, etc.

Reference to Another Patient

If it is necessary to refer to another patient to describe an event, the other patient's name should not be used. The medical record number can be referenced instead.

Authentication

The purpose of authentication is to show authorship and assign responsibility for an act, event, condition, opinion, or diagnosis. Every entry in the health record must be authenticated by the author and should not be made or signed by someone other than the author. This includes all types of entries such as narrative/progress notes, assessments, flowsheets, orders, etc., whether in paper or electronic format.

The Rules of Evidence indicate that the author of an entry is one who has knowledge of the act, event, condition, opinion, or diagnosis. Only the author of the entry would have this type of knowledge. The Federal Regulations/ Interpretive Guidelines for Hospitals (482.24(c)(1)(i)) indicate that only the author of an entry authenticates his or her entry. The author must also complete a specific action to indicate the entry is verified and accurate. The interpretive guidelines specifically identify unacceptable authentication: "failure to disapprove an entry within a specific time period is not acceptable as authentication. Auto-authentication, in which a physician or other practitioner authenticates a report before transcription, is not consistent with the requirements. There must be a method of determining that the practitioner did, in fact, authenticate the document after it was transcribed."[3]

There are various acceptable methods for authentication of an entry. Each healthcare organization must identify the proper and acceptable method of authentication for the type of entry, taking into consideration state regulations and payer requirements.

Signature

Entries in a paper-based record are usually authenticated by a signature in a paper-based record. At a minimum, the signature should include the first initial, last name, and title/credential or discipline (482.24(c)(1)). A healthcare organization can choose a more stringent standard requiring the author's full name with title/credential to assist in proper identification of the writer. If there are two people with the same first initial and last name, both must use their full signatures (and/or middle initial if applicable). Healthcare organization policies should define the acceptable format for signatures in the health record.

Countersignatures

Countersignatures should be used as required by state law. The person who is making the countersignature must be qualified to countersign. For example, licensed nurses who do not have the authority to supervise should not be countersigning an entry for a graduate nurse who is not yet licensed. Practitioners who are asked to countersign should do so carefully. The Interpretive Guidelines for hospitals (482.24(c)(1)(i)) require that medical staff rules and regulations should identify the types of documents nonphysicians may complete the entries that require a counter signature by a supervisory or attending medical staff member.

Initials

Any time a healthcare organization chooses to use initials in any part of the record for authentication of an entry, there has to be corresponding full identification of the initials on the same form or on a signature legend. Initials can be used to authenticate entries such as flow sheets, medication records, or treatment records, but should not be used in such entries as narrative notes or assessments. Initials should never be used where a signature is required by law.

Fax Signatures

The acceptance of fax documents and signatures is dependent on state, federal, and reimbursement regulations. Unless specifically prohibited by state regulations or healthcare organization policy, fax signatures are acceptable. The Federal Rules of Evidence and the Uniform Rules of Evidence allow for reproduced records used during the course of business to be admissible as evidence unless there is a genuine question about its authenticity or the circumstances dictate that the original be admissible rather than a reproduction. Some states have adopted the Uniform Photographic Copies of Business and Public Records Act, which allows for the admissibility of a reproduced business record without the original. The Uniform Business Records as Evidence Act adopted by various states also addresses the admissibility of reproductions.[4] When a fax

document/signature is included in the health record, the document with the original signature should be retrievable from the original source.

Electronic/Digital Signatures

Electronic signatures are acceptable if allowed by state, federal, and reimbursement regulations. State regulations and payer policies must be reviewed to assure acceptability of electronic signatures when developing healthcare organization policies. ASTM and HL7 have standards for electronic signatures.

If electronic signatures are used in the health record, the software program/technology should provide assurance that the following standards are met as outlined in the HIPAA proposed security rule:

- **message integrity**: the message sent or entry made by a user is the same as the one received or maintained in the system
- **non-repudiation**: assurance that the entry or message came from a particular user. It will be difficult for a party to deny the content of an entry or creating it
- **authentication**: confirms the identity of the user and verifies that a person really is who he says he is

The Federal Regulations/Interpretive Guidelines for Hospitals 482.24 (c)(1)(i)) also allow an entry to be authenticated by computer code. The author enters a computer code to approve an entry.

Rubber Stamp Signatures

Rubber stamp signatures are acceptable if allowed by state, federal, and reimbursement regulations. From a reimbursement perspective, some fiscal intermediaries have local policies prohibiting the use of rubber stamp signatures in the health record even though federal regulation allows for their use. Healthcare organization policies should define if rubber stamp signatures are acceptable and define the circumstances for their use after review of state regulations and payer policies. If used, the organization should have a letter on file stating that he/she is the only one who will use that rubber stamp.

Authenticating Documents with Multiple Sections or Completed by Multiple Individuals

Some documentation tools, particularly assessments, are set up to be completed by multiple staff members at different times. As with any entry, there must be a mechanism to determine who completed information on the document. At a minimum, there should be a signature area at the end of the document for staff to sign and date. Staff who have completed sections of the assessment should either indicate the sections they completed at the signature line or initial the sections they completed.

Signature Legends

A signature legend may be used to identify the author and full signature when initials are used to authenticate entries. Each author who initials an entry must have a corresponding full signature on record.

Permanency of Entries

All entries in the health record, regardless of form or format, must be permanent (manual or computerized records). The Rules of Evidence require policies and procedures to be in place to prevent alteration, tampering, or loss.

Ink Color

For hard copy/paper records, blue or black ink is preferred to assure readability when records are copied. The ink should be permanent (no erasable or water-soluble ink should be used). Never use a pencil to document in the health record.

Printer

When documentation is printed from a computer for entry in the health record, the print must be permanent. For example, a laser printer would be used rather than an ink jet printer because the ink is water soluble.

Fax Copies

When fax records are maintained in the health record, the assurance must be made that the record will maintain its integrity over time. For example, if thermal paper is used, a copy must be made for filing in the health record because the print on thermal paper fades over time. (See section on fax signatures for admissibility as evidence.)

Photocopies

The health record should contain original documents whenever possible. There are times when it is acceptable to have copies of records and signatures, particularly when records are sent from another healthcare organization or provider. (See section on fax signatures for admissibility as evidence.)

Carbon Copy Paper (NCR)

If there is a question about the permanency of the paper (i.e., NCR or carbon paper), a photocopy should be made. Policy should indicate when items are copied and how the original is disposed. At times, carbon copies of documents may be used on a temporary basis and the original will replace the carbon.

Use of Labels in the Health Record

Labels or label paper (adhesive-backed paper) are used for a variety of reasons including patient demographics, transcription of dictated progress notes, printing of physician orders for telephone orders, medication, or treatment records. When labels are used in the record, a number of issues or concerns must be considered and addressed before implementation. Healthcare organization policies and practices should address how and where labels will be used as well as the following issues:

- If labels are to be used in the health record, **selection of a label vendor** and/or type of label requires careful consideration. Because labels lose their adhesiveness over time, organizations must select a vendor and labels that offer a guarantee on length of time the labels will **retain adhesiveness**. The length of time should be consistent with the average length of stay for patients in the healthcare organization plus the retention period for health records after discharge. A guarantee of 10 years should be adequate for most organizations. The label should also be considered permanently adhesive shortly after being affixed to the backing sheet (some labels do not adhere permanently for 24 hours after placing it on a backing sheet, allowing for possible removal).
- Basic **patient identification information** should be included on each label, should it become dislodged from the backing sheet, to ensure that the label/entry can always be tracked to the proper patient's record. If the label paper is used for documentation such as a progress note or order, the date and signature should also be included on the label.
- If an error was made on a label, another label should never be placed over the original. Proper **error correction procedures** should be used for the entry.
- Labels must **never be placed over other documentation** in the health record. This would be the equivalent of using whiteout or blacking out an entry in the record and is not acceptable.
- When labels are computer-generated, the **printer ink must be permanent** (i.e., a laser printer is permanent whereas an ink jet printer is usually water soluble).

Corrections, Errors, Omissions, and Other Documentation Problems

There will be times when documentation problems or mistakes occur and changes or clarifications will be necessary. Proper procedures must be followed in handling these situations. ASTM and Health Level Seven (HL7) have standards that apply to error correction.

Error Correction Procedure

When an error is made in a health record entry, proper error correction procedures must be followed.

- draw a line through the entry--a thin pen line. Make sure that the inaccurate information is still legible
- sign and date the entry
- state the reason for the error in the margin or above the note if room
- document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry

Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, writing over an entry, etc. Correcting an error in electronic/computerized health record systems should follow the same basic principles. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry in a computerized health record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where a hard copy is printed from the electronic record, the hard copy must also be corrected.

Omissions in Documentation

At times it will be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement entries previously written.

Late Entry

When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the health record.

- identify the new entry as a "late entry"
- enter the current date and time. Do not try to give the appearance that the entry was made on a previous date or time
- identify or refer to the date and incident for which the late entry is written
- if the late entry is used to document an omission, validate the source of additional information as much as possible (for example, where you obtained the information to write the late entry)
- when using late entries, document as soon as possible. There is no time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes

Addendum

An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum:

- document the current date and time
- write "addendum" and state the reason for the addendum referring back to the original entry
- identify any sources of information used to support the addendum
- when writing an addendum, complete it as soon after the original note as possible

Entering a Clarification

Another type of late entry is the use of a clarification note. A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted. To make a clarification entry:

- document the current date and time
- write "clarification" and state the reason and refer back to the entry being clarified
- identify any sources of information used to support the clarification
- when writing a clarification note, complete it as soon after the original entry as possible

Altering a Dictated Report or Note

It is acceptable for a draft of a dictated and transcribed note/report to be changed prior to authentication unless there is a reason to believe the changes are suspect and would not reflect actual events or actions. Facility policy should define the acceptable period of time (i.e. 24 to 72 hours) allowed for a document to remain in draft form before the author reviews and approves it. Once a document is no longer considered a draft or has been authenticated, any changes or alterations should be made following the procedures for a late entry, addendum, or clarification. The original document must be maintained along with the new revised document.

Omissions on Medication, Treatment Records, Graphic, and Other Flowsheets

It is considered willful falsification and illegal to go back and complete and/or fill in signature "holes" on medication and treatment records or other graphic/flow records in the health record. Healthcare organization protocol should establish procedures for documenting a late entry when there is total recall and other supporting information to prove that a medication or treatment was administered. At no time should the records be audited after a period of time (such as the end of month) with the intent of identifying omissions and filling in "holes."

Documenting Care Provided by a Colleague

Documentation must reflect who performed the action. It is absolutely necessary to document care given by another person. For example, if a call is received from a nurse from the previous shift who indicates that he/she forgot to chart something in the record, enter the date and time of the telephone call along with the entry. The note should be signed and initials should be placed on the medication record as follows. When the nurse returns to work, she should review the note for accuracy and countersign it. She should also place her initials by the entry on the medication record. If there is not adequate room on the medication record, the initials are entered on the medication record and the entry is circled. On the back of the medication record, document the entry.

Patient Amendments to the Record

Healthcare organizations should have policies to address how a patient or his or her representative can enter amendments into his or her health record. The HIPAA privacy rule requires specific procedures and time frames to be followed for processing an amendment. A separate entry (progress note, form, typed letter, etc.) can be used for patient amendment documentation. The amendment should refer back to the information questioned, date, and time. The amendment should document the information believed to be inaccurate and the information the patient/legal representative believes to be correct. The entry in question should be flagged to indicate a related amendment or correction. At no time should the documentation in question be removed from the chart or obliterated in any way. The patient cannot require that the records be removed or deleted. ASTM and HL7 have standards related to amendments.

Maintaining Integrity

An important aspect of maintaining a legally sound health record is securing the record to prevent loss, tampering, or unauthorized use. The integrity of the health record may be questioned in a legal proceeding if concerns are raised about the security of paper-based or electronic records. The Rules of Evidence require an organization to have policies and procedures in place to protect against alterations, tampering, and loss. Systems and procedures should also be in place to prevent loss (such as tracking and sign-out procedures), secure record storage areas or systems, and limit access to only authorized users.

To ensure health records are not lost, stolen, or altered, the original health record should not be removed from the healthcare organization. The organization's policies should specifically address removal of records and prohibit any employee, contractor, or agent from removing patient health records (in full or in part) from the healthcare organization. When records are requested for legal proceedings, it is acceptable to submit a copy of the original.

If the original record is specifically requested for a legal proceeding, every effort should be made to submit a copy. For example, contact the court requesting that a copy versus the original be submitted or go to court with the original record and a copy. Request that the copy be placed into evidence rather than the original record. If the original must be placed into evidence, obtain a receipt from the court clerk and retain a copy of the record.

If it is absolutely necessary to remove the original record, measures should be in place to physically protect the original. One possible method is to utilize storage bags with plastic locks, which can be purchased through health record supply companies. The bag can be locked at the healthcare organization and the lock broken once at the destination. If the original record must be removed from the healthcare organization, it should always stay in the custody of a healthcare organization representative who takes full responsibility for its safe keeping.

Destruction

Records should be destroyed in a consistent manner based on established plan and procedures. Destruction is acceptable unless there is concern that certain records or documents were selected for destruction. When this happens, the behavior is considered suspect and it can appear that information that was harmful to the healthcare organization was destroyed.[5]

Healthcare organizations should develop basic documentation and record maintenance procedures to assure the legal integrity of their health records. The record can be an asset or a liability depending on an organization's adherence to sound legal practices and guidelines.

Notes

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