MAINTENANCE AND ORGANIZATION OF MEDICAL RECORDS

PURPOSE

Having an established location for all medical records, or a method of tracking the location of all patient charts when charts are stored in multiple locations, assures retrieval of all records when needed. Consistency in filing medical records assures information is readily available and easily found.

POLICY

It is the policy of the facility that all patients evaluated and treated by the sleep facility medical staff and those directly referred will have an individual medical record in either written or electronic format. All records will be maintained in an organized and consistent manner.

PROCEDURE

1.0 Use of an electronic medical record system

    1.1 All patients that have any sleep related services will have a medical record created in the electronic medical record (EMR) system. This will not be limited only to those requiring a sleep study.

        1.1.1 All medical records stored in the EMR will be compliant with HIPAA confidentiality and security rules and will be password protected.

        1.1.2 All patient-related health and other information as indicated by the system required for medical or financial reasons will be appropriately entered into the EMR system.

        1.1.2.1 Demographic information

        1.1.2.2 Financial and billing information

        1.1.2.3 Referral documentation

        1.1.2.4 Consultation notes and evaluations and treatment notes

        1.1.2.5 After interpretation, the sleep laboratory report is uploaded to the patient's electronic medical record by the daytime polysomnographer.

- Results can be reviewed in Epic by selecting "Results Review" from the activity list
- The actual report can be viewed as an image once "Sleep Lab Result" is selected and opened

    1.2 Only those employees that have been appropriately screened and given authority will have access to the EMR system.

    1.3 Patient medical records will have an automatic computer system back up daily with files stored at an offsite location.

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    1.4 The daytime sleep staff is responsible for all filing and maintenance of the contents of the medical record as designated by the facility manager.

2.0 Use of a paper medical record
    2.1 All patients that will have any sleep-related services, including those who did not have a sleep study, will have a paper medical record maintained.
    2.2 All medical records will be kept in locked file cabinets maintained in the control/technical room.
    2.3 The contents of the medical record will include but not be limited to:
        2.3.1 Referral form to include all demographic and financial/billing information
        2.3.2 Authorization and consent for services
        2.3.3 Physician order forms
        2.3.4 History and physical evaluations
        2.3.5 Medications record
        2.3.6 Patient questionnaires and screening assessments
        2.3.7 All consultations with facility director/medical staff members
        2.3.8 All documentation made by technologists
        2.3.9 All sleep studies and interpretation notes
        2.3.10 Signed indication by the facility director/medical staff member of authorization and approval for study if patient directly referred
    2.4 Only those individuals that have been given authority by the facility manager (e.g., technologists, billing personnel, and administrative staff) will have access to the medical record.