OREGON STATE HOSPITAL

POLICY

SECTION 2:	Clinical Support	**POLICY: 2.018**
SUBJECT:	Complete Medical Record	
POINT PERSON:	Health Information Manager	
APPROVED:	Dolores Matteucci Superintendent	**DATE: MARCH 13, 2024**

SELECT ONE:

- ○ New policy
- ○ Minor/technical revision of existing policy
- ◉ Reaffirmation of existing policy
- ○ Major revision of existing policy

PURPOSE AND APPLICABILITY

A. This policy is to guide staff on maintaining complete patient medical records for the purposes of communication, accountability, and coordination of care and services.

B. This policy applies to all staff.

POLICY

A. Oregon State Hospital (OSH) will establish a medical record for every patient admitted for care or evaluation. A patient's medical record is systematic documentation about a patient's condition, care, and treatment. It is maintained for purposes of communication, accountability, and coordination of care and services. This policy defines the components of a complete medical record consistent with applicable state and federal regulations.

B. Each medical record must contain sufficient, accurate information to identify the patient, support the diagnosis, justify admission and continued hospitalization, justify care and treatment, describe the patient's progress and response to medication and services, and promote continuity of care.

C. The record is contained in a paper medical record and an electronic health record (EHR). Only forms and documents approved by the Medical Records Committee may be filed in the medical record. The medical record must be filed according to the "Master List of Medical Record Forms" for all current form formats and documentation locations.

D. The inpatient medical record consists of the following information:
   1. Face Sheet
   2. Diagnoses
   3. Patient picture
   4. Psychiatry Discharge summary
   5. Medical History and Physical
   6. Assessments (*i.e.*, various discipline and specialized assessments such as risk, sex offending)
   7. Consultations
   8. Progress notes
   9. Group notes
   10. Treatment care plan
   11. Seclusion and restraint records
   12. Orders – medication, treatment, etc.
   13. Patient monitoring flowsheets
   14. Medication administration records
   15. Immunization records
   16. Diagnostic tests and reports (*e.g.,* labs, X-rays)
   17. Informed consents (*e.g.,* medication, treatment)
   18. Advance directives (*e.g.*, medical, mental health)
   19. Legal documents (*e.g.,* court orders for commitment, guardianship papers)
   20. Correspondence (*e.g.*, patient statement, letters from patient and/or family to staff, staff letters to patient, family or others regarding the patient and as needed to provide care, treatment and services, records of communication with the patient such as telephone calls or emails)
   21. Other healthcare provider records completed during the patient's OSH hospitalization.

E. Patient-related information ***not*** considered a part of the medical record but may be filed with the medical record includes, but is not limited to the following:
   1. Financial records
   2. Court-ordered reports (*e.g.,* 161.370 evaluations)
   3. Other legal records (*e.g.,* such as those received from the police or law enforcement related to an instance offense or crime)

4. Outside healthcare provider records (*i.e.,* historical health records from other hospital inpatient stays or outpatient service providers)
5. Other state-issued records (*e.g.,* Department of Motor Vehicles, Medical Examiner)

F. Other patient-related information listed below is not considered part of the complete medical record and may not be filed with the medical record:

1. Psychological raw test data
2. Billing records
3. Grievances
4. Incident reports

G. The medical record must meet all state, federal, and other regulatory and accreditation requirements. OSH will audit medical records to verify compliance with policy and applicable regulations.

H. All entries must be signed, dated and timed per OSH Policy 6.045, “Clinical Documentation”.

I. Medical record information must be promptly completed and filed within 30 days of a patient’s discharge in accordance with 42 C.F.R. 482.24(c) and OSH Policy 2.014, “Medical Record Maintenance and Transportation.”

J. This policy applies to all staff, including employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH. Staff who fail to comply with this policy or related procedures may be subject to disciplinary action, up to and including dismissal.

K. Oregon State Hospital (OSH) follows all applicable regulations, including federal and state statutes and rules; Oregon Department of Administrative Services (DAS), Shared Services, and Oregon Health Authority (OHA) policies; and relevant accreditation standards. Such regulations supersede the provisions of this policy unless this policy is more restrictive.

L. Staff who fail to comply with this policy or related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal.

DEFINITIONS

A. “Staff” includes employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at Oregon State Hospital (OSH).

RELATED OSH POLICIES AND PROTOCOLS

OSH Policy 2.006 “Public Records Retention and Destruction”

OSH Policy 2.009 “Medical Record Forms Management”

OSH Policy 2.013 “Electronic Health Record Access”

OSH Policy 2.014 “Medical Record Maintenance and Transportation”

OSH Policy 6.045 “Clinical Documentation”

OSH Policy 7.003 “Photographic and Recording of Patients”

REFERENCES

42 CFR § 482.24.

Joint Commission Resources, Inc. (2021). *The joint commission comprehensive accreditation manual for hospitals*, RC.01.01.01 – RC.02.04.01. Oakbrook Terrace, IL: Author.

Oregon Administrative Rule § 333-505-0050.