Policies and Procedures
Business Practices

Documentation Integrity

Policy Number: 0000

I. POLICY

It is the policy of this organization to ensure that the protected health records of individual served is maintained in a manner that is consistent with the legal requirements. All documentation will be current, standardized, detailed, organized, and available to practitioners and staff at each encounter. It is our policy that all documentation will facilitate coordination and continuity of care and permits effective, timely, quality review of care and supports.

II. PURPOSE

This policy establishes standard guidelines for the contents, maintenance, and integrity of individual documentation in order to meet the requirements set forth in Federal and State laws and regulations and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the health care record of care and supports delivered.

III. DEFINITION

None

III. ELIGIBILITY

This policy applies to all employees.

IV. PROCEDURE

1. Confidentiality: All employees having access to protected health records must sign the organizations confidentiality statement. All individuals and/or their guardians are afforded the opportunity to consent to or deny the release of identifiable medical or other information except as required by law. Each individual record will be filed, stored, and restricted from public access and will utilize a standardized and centralized network tracking system. This system will assure ease of retrieval, availability and accessibility as well as the confidentiality of the individual protected health record. All individuals will have the ability to review, inspect and/or obtain a copy of their Protected Health Information stored in their Health Record.

2. Information Governance: This organization will manage information as an asset and adopt proactive decision making and oversight for information asset management and governance to achieve data trustworthiness and to avoid erroneous, incomplete, redundant, or untrustworthy data and records.

    a. Template Documentation – templates will play an important role in improving the efficiency of data collection and ensure that all relevant elements are collected in a structured format. The following standards will govern template documentation design;

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i. Templates should not include pre-defined documentation. The structure of the note must be a good clinical fit and must accurately reflect the individual's condition and services.

ii. Templates will include options to document multiple problems or extensive interventions for the care & support provided.

iii. While templates will be designed to meet reimbursement criteria and to streamline documentation, they will include options to assure all relevant clinical information is captured to support the reasonable and necessary delivery of care.

b. Cloning & Copy/Paste Practices: the organization will adopt departmental procedures to assure limitations are defined for "copy and paste" documentation and functionality within an electronic health record. These procedures should be construed as applying to any feature which allows a provider to document a series of typed characters in order to quickly document portions of a service note and/or progress note.

3. Client Identification: All documentation will identify the individual served including name, date of birth, and record number. The organization will adopt any additional identity integrity controls to assure that key demographic data on forms are accurate and used to link records within and across systems.

4. Authorship Integrity: All documentation will track origin or creation of a particular record of information to a specific individual or entity acting at a particular time. When there are multiple authors or contributors to a document, all signatures will be retained so that each individual's contribution is unambiguously identified.

5. Record Amendment Integrity: Addendums, corrections, deletions, and amendments will be included in the record as defined by federal HIPAA laws. In order to support the integrity of the health record, the organization will allow providers to make amendments, have the ability to track corrections, and identify that an original entry has been changed. Procedures will be implemented that outline when changes need to be made, what changes can be made, who can make the changes, and how these changes will be tracked and monitored.

6. Audit Integrity: Audits are essential for ensuring that the health record documentation supports the level of service reported, that all payer requirements for reimbursement are met, and that only authorized users are accessing or making entries to individual records. The organization will conduct routine, scheduled internal audits for examining and evaluating the adequacy and effectiveness of these controls.

Reviewed by:
Content Owner:

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