

SUBJECT: SCOPE OF SERVICE	REFERENCE #3003
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	PAGE: OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

- The Health Information Management Department is responsible for overseeing the timely processing, completeness and when necessary, the retrieval of all patient medical records.
- The scope of services provided by the Health Information Management Department is based upon a collaboration and information sharing format to enhance patient care. Health Information Management services are provided to all areas of the facility, as appropriate to need and security levels. Health Information Management services include provision of an accurate patient record, with emphasis on the following:
 - Record processing
 - Record abstracting, analysis and coding
 - Transcription of dictation for the medical record
 - Correspondence
 - Record retrieval, filing and storage
 - Birth certificate function
- The scope of services also encompasses efforts made to provide:
 - More timely and easier access to complete information throughout the organization;
 - Improved data accuracy;
 - Demonstrated balance of proper levels of security versus ease of access;
 - Use of aggregate data, available through computerized reporting in the Health Information Management Department, to assist all healthcare providers with information that allows for identification of opportunities to improve performance;
 - Accessibility of the medical record at all times to those authorized persons requesting their use for patient care;
 - Transcription service is available to all physicians on a 24-hour basis. All documents received will be placed in the chart as soon as possible to ensure timely access to this information;
 - Availability of Health Information Management Department personnel seven (7) days per week during regular business hour. During off hours, personnel are available by

POSITION DESCRIPTION / PERFORMANCE EVALUATION

Job Title: HIM Technician

Supervised by: HIM Director

Prepared by: _____ Date: _____

Approved by: _____ Date: _____

Job Summary: Reviews medical records after discharge for completeness in compliance with the hospital's bylaws, JCAHO, federal and state requirements. Assures that patient abstracts are correctly entered into the chart deficiency system.

DUTIES AND RESPONSIBILITIES:

E = Exceeds the Standard

M = Meets the Standard

NI = Needs Improvement

Demonstrates Competency in the Following Areas:

	<u>E</u>	<u>M</u>	<u>NI</u>
Collects all discharged patient charts from the patient care units on a daily basis.	2	1	0
Collects loose filing for those discharged charts and inserts such filing in proper chart.	2	1	0
Combines current patient chart with any previous patient discharges for a unit record.	2	1	0
Assembles discharged patient charts according to assembly list.	2	1	0
Places assembled chart in proper folder according to medical record number.	2	1	0
Analyzes medical records of discharged patients for completeness and accuracy according to department and hospital policy and procedures.	2	1	0
Enters deficiencies into computer for physician completion.	2	1	0
Forwards all analyzed charts to the Coder.	2	1	0
Performs performance improvement audits on each chart as directed by the director.	2	1	0
Assists in answering telephone and taking accurate messages.	2	1	0
Is familiar with pediatric and SNF charting requirements.	2	1	0
Maintains hospital requirements, policies and standards on confidentiality.	2	1	0
Assists in retrieving charts for physician completion.	2	1	0
Assists in filing discharged patient loose sheets when time permits.	2	1	0
Willing to accept additional assignments.	2	1	0
Must be able to keep up with workload. Be able to process a minimum of 20 charts per day.	2	1	0
Maintains a good working relationship within the department and other departments.	2	1	0
Must be familiar with the following manuals: Administration, Health Information Management Department, Fire Safety, Emergency Management and Safety.	2	1	0

Professional Requirements:

	<u>E</u>	<u>M</u>	<u>NI</u>
Adheres to dress code, appearance is neat and clean.	2	1	0
Completes annual education requirements.	2	1	0
Maintains regulatory requirements.	2	1	0
Maintains patient confidentiality at all times.	2	1	0
Reports to work on time and as scheduled, completes work within designated time.	2	1	0
Wears identification while on duty, uses computerized punch time system correctly.	2	1	0

SUBJECT: HEALTH DATA INTEGRITY	REFERENCE #6004
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	PAGE: 1
	OF: 1
APPROVED BY:	EFFECTIVE:
	REVISED:

POLICY:

It is the policy of _____ Hospital to protect the privacy of individual identifiable health information. Believing that confidentiality is essential in developing the trust between patients and their providers of healthcare, we are committed to ensuring that patient medical information be disclosed only with informed consent or by statute.

PROCEDURE:

- The Information Management Committee is responsible for the development of organizational standards, policies and procedures concerning timeliness, accuracy, security, confidentiality, access, integrity and uniformity of data of both paper and electronic records.
 - Security/Confidentiality of Information:
 - To provide a balance between data sharing and data confidentiality, individuals/departments have been identified with specific policies/procedures outlining the access to, and need for, data and information.
 - Health Information Management Department personnel will have access to all documentation present in the medical record in accordance with Information Management Committee approved policies and procedures.
 - Nursing personnel will have access to all pertinent patient information to allow for optimum assessment, treatment and care of the patient in accordance with general nursing policies and procedures.
 - Medical staff will have access to all pertinent patient information that will allow them to render optimum treatment to any patient for whom they are the attending, covering or consulting physician in accordance with the medical staff bylaws.
 - Clerical personnel will have access to all necessary patient information that allows for appropriate billing, insurance and financial procedures.
 - Health Information Management Department will have access to patient information for reporting purposes in accordance with departmental policies and procedures.
 - All other individuals, including ancillary personnel and administrative personnel, will have access to patient data and information on an “as needed” basis, restricted to level of authority, in accordance with hospitalwide policies and procedures governing information security and confidentiality.
 - De-Identified Information:

SUBJECT: MEDICAL RECORD CONTENT	REFERENCE #6064
DEPARTMENT: HEALTH INFORMATION MANAGEMENT	PAGE: 1 OF: 1
APPROVED BY:	EFFECTIVE: REVISED:

POLICY:

It is the policy of _____ Hospital that the medical record shall contain sufficient information to identify the patient, support the diagnosis, to justify the treatment and document the results accurately.

PROCEDURE:

- The Admitting Department is responsible for collecting sufficient information to identify the patient. The information is documented on the face sheet, which is a permanent part of the patient's record.
- Emergency care, treatment and services received by the patient before his/her arrival at the hospital are documented.
- The legal status of patients who are receiving behavioral healthcare services will be documented in the patient's medical record.
- The history and physical examination is recorded in the medical record at the time of the patient's admission. It shall be obtained from the patient when possible and include:
 - Chief complaint
 - History of present illness
 - Relevant past medical history, family and social history
 - Allergies to medications and foods
 - Review of systems, including a minimum review of the cardiovascular, respiratory, genitourinary and gastrointestinal systems
 - For a child or adolescent, there is mention of developmental age factors, consideration of educational needs and daily activities, height, weight, as appropriate, patient's immunization status, family's and/or guardian's expectations for, and involvement in, the assessment of, treatment and continuous care of the patient
 - Obstetrical records including all prenatal information, which may be a copy from the physician's office
 - A report of the physical examination, which must include all body systems, pelvic, rectal and breast exams, when applicable. If these are deferred, there must be statement by the physician as to the plans for follow-up or results of a recent exam

SUBJECT: LEGIBILITY OF MEDICAL RECORD DOCUMENTATION	REFERENCE #6074
	PAGE: 1 OF: 1
DEPARTMENT: HOSPITALWIDE	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- It is the policy of _____ Hospital to set legibility standards for medical record documentation and to monitor compliance with these standards as part of our performance improvement and medical error reduction activities.
- This policy is applicable to all documentation within the medical record.

PROCEDURE:

- Whenever possible, all consults, histories and physicals, interpretations of diagnostic testing, and post operative/procedure results shall be dictated.
- Only abbreviations listed in the organization’s list of approved abbreviations will be allowed for use in medical record documentation.
- Medication Orders:
 - Should include a brief notation of purpose.
 - All prescription orders are to be written in the metric system.
 - “Units” should be spelled out.
 - The order must include drug name, exact metric weight or concentration and dosage form.
 - A leading zero must precede a decimal expression of less than one.
 - A terminal zero is not to be used after a decimal.
 - Prescribers are to avoid the use of abbreviations for drug names and Latin directions for use.
 - The age and weight of the patient (especially geriatric and pediatric patients) should be included where appropriate.
- If a healthcare professional writes an order that is not legible, the order must be clarified with the healthcare professional prior to implementation.
- Clarification of orders will be documented on the order sheet as a “clarification”, timed and dated and signed by the healthcare professional receiving the clarification.