The Paper Medical Record
Introduction

Medical records management systems are only as good as the ease of retrieval of the data in the files.

Organization and adherence to set routines will help to ensure that medical records are accessible when they are needed.
This chapter will examine:

• Reasons for keeping accurate records
• Ownership of records
• Differences among types of records
• Differences among types of information
• Making corrections in the record
• Filing procedures and systems
• Forms found in medical records
Why Medical Records Are Important

- Assist the physician in providing the best possible care to the patient
- Offer legal protection to those who provide care to the patient
- Provide statistical information that is helpful to researchers
- Vital for financial reimbursement
Ownership of the Medical Record

• The maker, who initiated and developed the record, owns the physical medical record.
• The maker can be a physician or a medical facility.
• Patients have a right of access to the information in the record.
Points to Remember

• Medical records must be kept confidential and in a secured, locked location.
• The record should never leave the medical facility in which it originated.
Types of Records

- Paper-based medical records
- Computer-based medical records
Disadvantages of Paper-Based Medical Records

- Only one person can use the record at a time, unless multiple people are crowding around the same record.
- Items can be easily lost or misfiled or can slip out of the record if not securely fastened.
- The record itself can be misplaced or be in a different area of the facility when needed.
Advantages of Computer-Based Medical Records

• More than one person can use the record at a time.
• Information can be accessed in a variety of physical locations.
• Records can often be accessed from another city or state.
• Complete information is often available in emergency situations.
Organization of the Medical Record

• Source-oriented records
• Problem-oriented records
Source-Oriented Medical Records (SORs)

• Traditional method of keeping patient records
• Observations and data are cataloged according to their sources such as an MD, Lab, Xray, etc.
• Forms and progress notes are filed in reverse chronological order. Example 2013, 2012, 2011...
• Separate sections are established for laboratory reports, x-ray films, radiology reports, etc.
• This method is time consuming for filing and searching.
## Problem-Oriented Medical Records (POMR)

Divides records into four bases:

1. Database
2. Problem list
3. Treatment plan
4. Progress notes

### Problem List

<table>
<thead>
<tr>
<th>DATE</th>
<th>#</th>
<th>PROBLEM OR CONDITION</th>
<th>PLAN</th>
<th>RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/18/97</td>
<td>1</td>
<td>URI with cough</td>
<td>cough syrup Codeine</td>
<td>8/17</td>
</tr>
<tr>
<td>4/2/00</td>
<td>2</td>
<td>hypertension</td>
<td>atenolol 50mg qd</td>
<td></td>
</tr>
<tr>
<td>5/8/04</td>
<td>3</td>
<td>Laceration right - 2&quot;</td>
<td>sutures - 6</td>
<td>6/14</td>
</tr>
<tr>
<td>10/19/04</td>
<td>4</td>
<td>pain right x 3 mo.</td>
<td>restenosis, x-ray - 9/18</td>
<td></td>
</tr>
</tbody>
</table>

*Courtesy Bibbero Systems, Petaluma, Calif.*
1. Database

Includes:

- Chief complaint
- Present illness
- Patient profile
- Review of systems
- Physical examination
- Laboratory reports
2. Problem List

• Numbered and titled list of every problem the patient has that requires treatment
• May include social and demographic troubles as well as medical and/or surgical notes
3. Treatment Plan

Includes:

- Management
- Additional workups needed
- Therapy

Each plan is titled and numbered with respect to the problem.
4. Progress Notes

• Structured notes are numbered to correspond with each problem number.

• Progress notes follow the “SOAP” approach.

• SOAP notes are kept in the medical records.

• SOAP progress notes are charted by the MD and are exactly what they are: PROGRESS notes.
SOAP Acronym:

SOAP:
S—Subjective impressions (patients information)
O—Objective clinical evidence (doctors information or clinical evidence)
A—Assessment or diagnosis
P—Plans for further studies, treatment, or management
Optional E—Evaluation or education
R—Response
What is Objective Information?

Objective findings, often called *signs*, are gained from the **physician’s examination** of the patient.

- Physical examination and findings
- Laboratory and radiology reports
- Diagnosis
- Treatment prescribed
- Progress notes
- Condition at the time of termination of treatment
CHEDDAR

• Another example an MD’s use is the “Cheddar” approach for charting progress.
• C—Chief complaint
• H—History
• E—Examination
• D—Details (of problem and complaints)
• D—Drugs and dosages
• A—Assessment
• R—Return visit
Personal and Medical History

• Often obtained by patient questionnaire

Should the MA use a questionnaire or interview? Depends on the office protocol.

What does this information entail?

• Provides information about any past illnesses or surgical operations
• Explains injuries or physical defects
• Information about the patient’s daily health habits
• Information about allergies, advance directives, living wills, and so on
Patient’s Family History

• Physical condition of members of the patient’s family
• Past illnesses and diseases family members may have experienced
• Record of causes of family members’ deaths
Patient’s Social History

• Information about the patient’s lifestyle
• Alcohol, tobacco, and drug use history
• Marital information
• Psychological information
• Emotional information, if pertinent
Patient’s Chief Complaint

- Nature and duration of pain, if any
- Time when the patient first noticed symptoms
- Patient’s opinion as to the possible causes of the difficulties
- Remedies that the patient may have applied or tried
- Whether the patient has had the same or similar condition in the past
- Past medical treatment for the same condition
Pain Scale

“How bad is your pain on a scale of 1 to 10, with “1” being like a mosquito bite and “10” being the worst pain you have ever experienced?”
Medical Assistant’s Role When Taking the Patient History

• Take the history in a physical location that ensures patient confidentiality.
• Ask open-ended questions.
• Obtain details of the patient’s condition and symptoms.
• Keep all information about the patient confidential.
Authentication

For a chart to be admissible as evidence in court, the person dictating or writing the entries must be able to attest that they were true and correct at the time they were written.

This is “authentication” and is best done by initialing entries made to the medical record.
Making Additions to the Record

- Place the most recent information on top.
- Physicians should read and initial reports before they are filed.
- Some offices direct only abnormal reports to the physician.
- Follow the office policy as to which method is used in that particular office.
Progress Notes

• Continually added to the medical record.
• Must list each patient visit and any notations about the visit.
• Instructions, prescriptions, and telephone calls for advice should be noted in the progress notes.
• Always initial entries in progress notes.
Making Corrections and Alterations to Medical Records

• First, verify the correct procedure as detailed in the policy and procedure manual.

• Never use correction fluid, erasers, or any other type of obliteration methods.

• Do not mark through information to obliterate it.

• Do not hide errors.

• If errors could affect the health and well-being of the patient, bring it to the physician’s attention immediately.
Correcting an Error

Three Steps

1. **Draw one line through the error.**
2. Insert the correction above or immediately after the error.
3. In the margin, write “correction” or “corr” and initial the entry, if indicated by the office policy and procedure manual.
Correcting Electronic Records

- If an error is made while typing, simply backspace and correct the error.
- If the error is discovered later, make an additional entry (addendum) with corrected information.
- Do not delete or change previous entries on electronic records.
Keeping Records Current

• Records must be methodically kept current.
• Do not allow histories and reports to accumulate for long before filing them.
• The patient’s health is jeopardized when current, accurate records are not available to the physician.
• Remember that the physician bases his or her decisions on the information in the patient’s medical record.
3 Classifications of Records in the Physician’s Office

• Active files
  – patients currently receiving treatment

• Inactive files
  – patients who have not been seen for about 6 months to a year.

• Closed files
  – patients who have died, moved away, or otherwise discontinued treatment
Transfer of Records

Follow office policies regarding transferring medical records from active to inactive or closed categories.
This process is called “purging.”

Files may need to be physically rearranged to accommodate transfers.
Most physicians keep medical records for 10 years at a minimum
Retention and Destruction

• Medicare and Medicaid patient records must be kept for at least 6 years.
• Keep records on patients who are deceased for at least 2 years.
• Follow office policies for record retention and destruction.
Releasing Medical Record Information

• Requests must be made in writing for release of records.
• Patients must sign an authorization for release of medical records.
• Patients can revoke previously signed authorizations for release of records.
• Release only records that are specified on the request.
Filing Equipment

Various types of equipment are available for storing medical records in today’s medical offices.
Color-Coding

• Almost all medical offices use some sort of color-coding in their filing systems.
• Numeric color-coding provides a high degree of patient confidentiality.
Color-Coding