AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines

Legal Documentation Standards

This section will review the legal documentation standards for entries in and maintaining the medical record. In today's healthcare environment health information is collected in various formats – paper-based, electronic resident records, and computerized resident databases. The legal documentation standards have mainly applied to a paper medical record, however, most are also applicable to documentation in an electronic medical record as well. This section is divided into three topics and will address the following issues:

- Purpose and definition of the legal medical record
- Legal documentation standards that apply to medical records
- Legal guidelines for handling corrections, errors, omissions, and other documentation problems

Purpose and definition of the Legal Medical Record [1]

A patient's health record plays many important roles:

1. It provides a view of the resident's health history - In other words, it provides, a record of the resident's health status including observations, measurements, history and prognosis, and serves as the legal document describing the health care services provided to the patient. The medical record provides evidence of the quality of resident care by -
    - Describing the services provided to the resident
    - Providing evidence that the care was necessary
    - Documenting the resident's response to the care and changes made to the plan of care
    - Identifying the standards by which care was delivered
2. Documenting adherence to company standards and procedures
3. It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the resident.
4. It provides supporting documentation for the reimbursement of services provided to the resident.
5. It is a source of data for clinical, health services, outcomes research as well as public health purposes.
6. It serves as a major resource for healthcare practitioner education.
7. It serves as the legal business record for a health care organization and is used in support of business decision-making.

There is not a one-size-fits-all definition of the legal record since laws and regulations governing the content vary by practice setting and by state. However, there are common principles to be followed in creating a definition.

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The following table "Guidelines for Defining the Health Record for Legal Purposes" breaks down the health record into four categories to provide guidelines for assisting health care organizations in defining the content of their legal record.

<table>
<tr><th colspan="2">Guidelines for Defining the Health Record for Legal Purposes</th></tr>
<tr><td>LEGAL HEALTH RECORD

The legal business record generated at or for a healthcare organization. This record would be released upon request.</td><td>The legal health record is the documentation of the healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization. The legal health record is individually identifiable data, in any medium, collected and directly used in and/or documenting health care or health status. The term includes records of care in any health-related setting used by healthcare professionals while providing patient care services, for reviewing patient data or documenting observations, actions, or instructions. Some types of documentation that comprise the legal health record (see examples listed below) may physically exist in separate and multiple paper-based or electronic/computer-based databases. Typically this includes records that are considered part of the active, overflow, and discharge chart.

The legal health records EXCLUDES health records that are NOT official business records of a healthcare provider organization (even though copies of the documentation of the healthcare services provided to an individual by a healthcare provider organization are provided to and shared with the individual). Thus, records such as Personal Health Records (PHRs) that are patient controlled,managed, and populated would not be part of the legal health record.

Copies of PHRs that are patient owned, managed, and populated by the individual but are provided to a healthcare provider organization(s)should be considered part of the legal health record. Such records are then used by healthcare provider organizations to provide patient care services, review patient data or document observations, actions or instructions. This includes patient owned, managed and populated "tracking" records, such as medication tracking records and glucose/insulin tracking records.

Examples of documentation found in the legal health record:
• Records of history and physical examination
• Multidisciplinary progress notes/documentation
• Immunization record
• Problem list
• Medication profile / Physician Orders and Renewals
• Consent for treatment forms
• Consultation reports
• Physical therapy, Speech therapy, and Occupational therapy records
• Email containing patient-provider or provider-provider communication
• Graphic records
• Intake/output records
• Nursing and other discipline assessment</td></tr>
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	• Care plan • Minimum data sets • Practice guidelines or protocols/clinical pathways that imbed patient data • Telephone orders • Advanced Directives • Discharge instructions, plan of care, etc.
PATIENT - IDENTIFIABLE SOURCE DATA *An adjunct component of the legal business record as defined by the organization. Often maintained in a separate location or database, these secondary records are provided the same level of confidentiality as the legal business record. The information is usually retrievable upon request.*	Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. Source data should be accorded the same level of confidentiality as the legal health record.These data are increasingly captured in multimedia form. For example,the videotape recording of the encounter would not represent the legal health record but rather would be considered source data.In the absence of documentation, (e.g., interpretations, summarization, etc.), the source data should be considered part of the legal health record. Examples of patient-identifiable source data: • Diagnostic films and other diagnostic images from which interpretations are derived • Electrocardiogram tracings from which interpretations are derived • Audio of dictation • Analog and digital patient photographs for identification purposes only • Videos of procedure
ADMINISTRATIVE DATA *Provided the same level of confidentiality as the legal health record, however, the data is not considered part of the legal health record (such as in response to a subpoena for the "medical record.")*	Administrative data are patient-identifiable data used for administrative, regulatory, and payment (financial) purposes Examples of administrative data: Authorization forms for release of information Correspondence concerning requests for records Event history/audit trails Protocols/clinical pathways, practice guidelines and other knowledge sources that do not imbed patient data Patient-identifiable claim Patient-identifiable data reviewed for quality assurance or utilization management Death Certificates Patient identifiers (e.g., medical record number, biometrics)
DERIVED DATA *Provided the same level of confidentiality as the legal health record, however, the data is not considered part of the legal health record (such as in response to a*	Derived data are data derived from patient records that are aggregated so that there are no means to identify patients. Examples of derived data: • Best practice guidelines created from aggregate patient data • Anonymous patient data for research purposes • ORYX report

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subpoena for the "medical record."	OASIS report • MDS report • Survey/Accreditation reports • Public health records • Statistical reports

[1] **Source:** Definition of the Legal Medical Record AHIMA's Legal Medical Record Task Force

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