

CENTRAL STATE HOSPITAL  
POLICY

SUBJECT: Record of Care, Lost, Destroyed or Stolen Records

ANNUAL REVIEW MONTH: New

RESPONSIBLE FOR REVIEW: Director, Information Management

LAST REVISION DATE: August 2009 (New Policy)

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**PURPOSE**

The purpose of this policy/procedure is to ensure that clients' medical information is protected and safeguarded at all times in accordance with the Department of Behavioral Health and Developmental Disabilities (DBHDD) and other regulatory agencies' standards. Even with the best preventative systems in place, medical records, in full or in part, can be inadvertently lost, destroyed, or stolen. To limit or minimize the harm, systems which protect clients records must be in place and enforced.

**CLINICAL (Medical) RECORD CREATION**

Federal and regulatory agencies require that the hospital such as CSH "must maintain clinical records on each client in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized". A separate, unique medical record is created and maintained for every client assessed and/or treated at Central State Hospital. The medical record is the documentation of all health care services provided to an individual, in any aspect of health care delivery. The record includes individually identifiable data, in any medium, collected and directly used in and/or for documenting medical care. The term (CLINICAL (Medical) RECORD CREATION) includes records of care in any medical-related setting used by medical care providers while providing client care services, to review client data or document own observations, actions, or instructions. The medical record includes all handwritten and computerized components of the documentation of clinical evaluations and any care rendered.

**LOST AND/OR STOLEN RECORDS**

When documents/records are lost or missing, an exhaustive search shall be conducted by designated staff to locate the document/records. Any event in which document/records were temporarily or permanently lost, will be treated as an incident requiring investigation to determine the root cause and corrective action will be developed and implemented.

## **GENERAL PRACTICES**

If a lost record cannot be found or is known to be destroyed or stolen, the medical record will be reconstructed to the fullest extent possible.

Reconstruction Process:

- Reprint documents from any databases that contain pertinent client information including but not limited to: Avatar, MDS, and pharmacy (WORX), laboratory, and radiology databases or data backup services.
- Retranscribe any pertinent documents from the hospital's centralized dictation system.
- Obtain copies from recipients of previously distributed reports/documents, such as those sent to other medical providers, if applicable.
- Obtain copies of reports generated by any other medical care facility (hospital) that relate to the client's stay (history and physical, discharge summary reports, etc.).
- Copy documents from any pertinent electronic formats and label as reprint.

If unable to reconstruct part of a client's medical information:

- Document the date the information was lost;
- Document the event precipitating the loss in the client's record;
- When information is disclosed that normally include the missing portion, include a copy of the entry documenting the loss of that information.

## **IMPROPER REMOVAL, TAMPERING, AND FALSIFICATION OF MEDICAL RECORD**

All clients' records are the property of the DBHDD and CSH has a duty to protect and preserve these records. The original medical record should never be removed from the hospital. When records are requested for legal proceedings, it is acceptable to submit a copy of the original. If the court requires the original medical record, the Health Information Management Director/Designee must take and stay with the record at all times. Any individual identified as willingly, intentionally, improperly removing, destroying, and falsifying client medical information shall be disciplined per hospital policy.

Failure to comply with this policy may be deemed a violation of:

1. Protection of Individually Identifiable Health Information-Compliance with HIPAA Privacy Rule
2. Standards of Conduct and Ethics in Government.
3. CSH Confidentiality Policy (*Policy 4.29*)
4. Official Code of Georgia Annotated 37-3-166, 37-4-125, 37-7-166

Violations include but are not limited to:

1. Failure to safeguard confidential information;
2. Careless or negligent workmanship in handling client medical information;
3. Deliberately corrupting, tampering and/or damaging client information;
4. Unauthorized intrusion of client information;
5. Falsifying official agency records.

#### **RETENTION, DISPOSITION OF MEDICAL RECORD**

It is the policy of the DBHDD to ensure that records are retained in a manner that is consistent with sound business practices and the facilities best practices in client care with particular regard to accessibility and confidentiality.

*(Reference MHDDAD Policy Number 14.800 Records Retention)*

**Approved:**

**This policy was approved by the CEO and CMO in September, 2009.**