Elements of healthcare maintaining health records report example

Law, Criminal Justice



Elements of Healthcare (Maintaining Health Records)

In any health facility, it is necessary to have policies that make necessitate the keeping of medical records. Keeping medical records of patients treated in a health facility is one practice of Health Information Management. This can be done in two ways: the traditional way which is paper -based and the electronic way where files are stored in a computer system. It is also important to note that keeping records is a requirement of the law (Roach, 2006, p. 12). However, it is up to the facility to come with ways and policies on how to do it.

Health Record Policy

Departments Affected: The Human Information Management, Information
Technology Department, Legal Issues Department, Risk Management
Department

Purpose: This policy is to identify ways of maintaining the integrity and confidentiality, as well as privacy of medical records.

Scope: This policy applies to all medical records that are legal. The policy also encompasses all records kept in whatever media, manual or electrical. However, any health record created against set regulations and standards is not affected by this policy.

Note Better: A legal health document is one whose content has been collected by a healthcare provider in accordance to policies and regulations of an individual health facility. The content is then used by medical officials

to help them as they administer treatment to the patient. This information should be easily accessible when needed. To ensure that a health document meets all the legal requirements, legal advice should be sought when formulating a policy, so as to know exactly what is constituted in a legal health document.

Policies

Health facilities should create and maintain health records that will help them as they provide their healthcare services.

Health facilities should meet all the legal requirements and standards. Health care facilities should have a mechanisms and ways to maintain integrity and confidentiality of healthcare records.

Responsibilities

The risk manager works hand in hand with the IT specialists, legal representative, and any other representative from a department deemed relevant to:

Create and maintain a document or system that checks the validity of each detail in the health record.

Identify what details need to be included in the health record and how to make corrections when needed.

Decide on what content to use when make crucial decisions in the healthcare facility.

Create and implement a strategy to help manage contents of the health record

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Develop ways to ensure the health records are safe and only accessible by a chosen few.

Develop strategies to maintain integrity confidentiality of the health records.

Ownership of Medical Records

Each state has got its own statutes and regulations on the ownership of medical records. However, general statutes and regulations state that medical records are owned by the health care provider who collects the information in the document (Pozgar, & Santucci, 2009, p. 175). This however should not be a factor that health care providers can use to deny a patient access to their medical records. This is because accessibility and ownership rights are two separate elements of the law.

A health provider should not deny a patient access to their medical records. However, a small fee is allowed to cater for photocopying expenses, to pay for clerical services, to pay for labor and time spent when trying to locate the health document, and to pay for professional expenses in instances where a doctor needs to review the document before releasing it. This fee should not be high. A patient has a right to launch an official complain if they feel that the fee they have been charged to view their medical records is too high (Pozgar, & Santucci, 2009, p. 180).

Medical health records are kept in the health facility for safety reasons such as keeping the information away from people who are not supposed to access it, and also to avoid chances where the information May be tampered with.

Medical records should be maintained in a form that is legible and available when requested for. The records should not be moved from the health facility unless in some special circumstances, and such exemptions are provided for by the law.

In some states, patients are allowed to make corrections or amendments to their medical records (Pozgar, & Santucci, 2009, p. 193). All a patient needs to do is request in writing that they want to correct or amend something, or even add some more information to what is already on their records. This privilege may differ depending on the individual health facility or even the state as a whole.

Policies and Procedures for the release of Records

One policy that regulates the release of medical records states that all information in a patient's medical records, manual or automated, should be maintained as being confidential in compliance with the state and federal regulations (Roach, 2006, p. 57). The policy goes on to state that patients have the right to send the information in their medical records to other medical experts from another facility or place.

Health information can only be disclosed to those involved in the treatment of the patient, public health officials, for payment of services when authorized by patient, to researchers when authorized by patient, or to any other person, so long as the patient has given their authorization.

The procedure for release of medical information is that those with the authorization to access the information sign an authorization form, after

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which the signature is checked for validity reasons. Another thing is that the authorization date should not date back more than an year (Roach, 2006, 59).

Ways to maintain Confidentiality and Integrity of Medical Records

Medical records should be kept safe and away from people who may use it in the wrong way or tamper with it. Several strategies have been formulated to ensure that there are reliable safeguards that help protect the privacy, security, and integrity of medical records. These measures are placed in a way that they do not hinder accessibility of the records to whoever may need it, so long as they are authorized to. The federal Health Insurance Portability and Accountability Act is an act that was established in 2003 to ensure the confidentiality and privacy of medical records is upheld (Keir, Wise, Krebs, & Kelley, 2007, p. 197).

The safeguards are classified into physical and technical safeguards (Keir, Wise, Krebs, & Kelley, 2007, p. 206). Physical safeguards include isolation of certain devices and storage rooms, allowing access to only a chosen few, ensuring there always is a backup for all existing data, and being keen when disposing off anything such as storage devices. Technological safeguards include making use of firewalls, encrypting the data, storing data using special codes that only a few people can understand, as well as making use of virtual private networks. The technological safeguards are best since they make use of the latest technology and are much easier to update, while at the same time, difficult to manipulate.

References

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