### PURPOSE

To define required clinical documentation and the process for periodic and ongoing review of the patient’s clinical record.

### POLICY

Clinical records will contain specific elements of documentation and be reviewed at least quarterly by qualified organization personnel to assure that documentation entered is reliable, timely, valid, and accurate.

### PROCEDURE

### *Clinical Record Documentation*

The Clinical Record will include:

1. The patient’s current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical visit notes, and individualized plans of care;
2. All interventions, including medication administration, treatments, services, and responses to those interventions, which would be dated and timed;
3. Goals in the patient’s plan of care and the progress toward achieving the goals;
4. Contact information for the patient and representative (if any);
5. Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency; and
6. A discharge or transfer summary note that would be sent to the patient’s primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency within 5 business days of the patient’s discharge or, if the patient is discharged to a facility for further care, within 2 business days of becoming aware of an unplanned discharge to the receiving facility if the patient is still receiving care.
7. All entries to be legible, clear, complete, and appropriately dated, and timed

### *Clinical Record Documentation*

1. Each clinical record will be reviewed on an ongoing basis by qualified organization personnel for:
   1. Compliance with organizational policy
   2. Compliance with the established plan of care
   3. The completeness of clinical records
   4. The accuracy of clinical records
   5. The appropriateness of services rendered
   6. The need for continued care
2. The clinical record review will consist of a process based on the following guidelines:
   1. The review will consist of a random sample selection of both active and inactive cases.
3. The sample will represent 10% of each program’s annual unduplicated admissions with a maximum of 120 sample records per year.
4. Of the 10% sample, 5% will be active patient clinical records and 5% will be discharged patients.
   1. Each professional discipline will participate in review of clinical records for their service.
   2. No person involved in the care of a patient may participate in the review of that patient’s record.
   3. All records will be reviewed using a clinical record review tool to:
5. Determine the adequacy of the plan of care and to determine if further service is necessary and appropriate
6. Determine that data is reliable, valid, and accurate
7. Record review findings will be documented and the data collated and analyzed.
8. Results will be utilized for improvements in patient care and incorporated into performance improvement plans and activities.
9. A summary of the results and corresponding analysis will be presented to the individual Home Health Agency’s Quality Assurance and Performance Improvement Committee.