A medical record, health record, or medical chart is the systematic documentation of a resident’s medical history and care. The term ‘Medical record’ is used both for the physical folder for each individual record and for the body of information which comprises the total of each resident’s health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

The information contained in the medical record allows health care providers to provide continuity of care to individual residents. The medical record also serves as a basis for planning resident care, documenting communication between the health care provider and any other health professional contributing to the resident’s care, assisting in protecting the legal interest of the resident and the health care providers responsible for the resident’s care, and documenting the care and services provided to the resident.

Traditionally, medical records have been written on paper and kept in charts and folders. These folders and charts are typically divided into useful sections, with new information added to each section chronologically as the resident experiences new medical issues. These records are stored at The Baptist Home. The advent of electronic medical records may change the format and access of medical records for which TBH will review and develop policies and procedures as needed.

Although the specific content of the medical record may vary depending upon specialty, it usually contains the resident’s identification information, the resident’s health history (what the resident tells the health-care providers about his or her past and present health status), and the resident’s medical examination findings (what the health-care providers observe when the resident is examined). Other information may include lab test results; medications prescribed; referrals ordered to health-care providers; educational materials provided; and what plans there are for further care, including resident instruction for self-care and return visits. Billing information is considered to be part of the medical record.

Demographics include resident information that is not medical in nature. It is often information to locate the resident, including identifying numbers, addresses, and contact numbers. It may contain information about race and religion as well as workplace and type of occupation. It may also contain information regarding the resident’s health insurance. It is common to also find emergency contacts located in this section of the medical chart.

The medical history is a longitudinal record of what has happened to the resident since birth. It chronicles diseases, major and minor illnesses, as well as growth landmarks. It gives the clinician a feel for what has happened before to the resident. As a result, it may often give clues to current disease states. It includes several subsets detailed below.

- **Surgical history**—is a chronicle of surgery performed for the resident. It may have dates of operations, operative reports, and/or the detailed narrative of what the surgeon did.
• **Obstetric history**—lists prior pregnancies and their outcomes. It also includes any complications of these pregnancies.

• **Medications and medical allergies**—the medical record may contain a summary of the resident’s current and previous medications as well as any medical allergies.

• **Family history**—lists the health status of immediate family members as well as their causes of death (if known). It may also list diseases common in the family or found only in one sex or the other. It may also include a pedigree chart. It is a valuable asset in predicting some outcomes for the resident.

• **Social history**—is a chronicle of human interactions. It tells of the relationships of the resident, his/her careers and trainings, schooling and religious training. It is helpful for the physician to know what sorts of community support the resident might expect during a major illness. It may explain the behavior of the resident in relation to illness or loss. It may also give clues as to the cause of an illness (e.g. occupational exposure to asbestos).

• **Habits**—various habits which impact health, such as tobacco use, alcohol intake, exercise, and diet are chronicled, often as part of the social history. This section may also include more intimate details such as sexual habits and sexual orientation.

• **Immunization history**—the history of vaccination is included. Any blood tests proving immunity will also be included in this section.

• **Developmental history**—many diseases and social stresses can affect growth and longitudinal charting and can thus provide a clue to underlying illness.

**MEDICAL ENCOUNTERS**

Within the medical record, individual medical encounters are marked by discrete summations of a resident’s medical history by a physician, nurse practitioner, or physician assistant and can take several forms. Hospital admission documentation (i.e., when a resident requires hospitalization) or consultation by a specialist often take an exhaustive form, detailing the entirety of prior health and health care. Routine visits by a provider familiar to the resident, however, may take a shorter form such as the **problem-oriented medical record** (POMR), which includes a problem list of diagnoses or a "SOAP" method of documentation for each visit. Each encounter will generally contain the aspects below:

• **Chief complaint**—this is the problem that has brought the resident to see the doctor. Information on the nature and duration of the problem will be explored.

• **History of the present illness**—a detailed exploration of the symptoms the resident is experiencing that have caused the resident to seek medical attention.

• **Physical examination**—is the recording of observations of the resident. This includes the vital signs, muscle power and examination of the different organ systems, especially ones that might directly be responsible for the symptoms the resident is experiencing.

• **Assessment and plan**—is a written summation of what are the most likely causes of the resident's current set of symptoms. The plan documents the expected course of action to address the symptoms (diagnosis, treatment, etc.).

**TYPES OF RECORDS**

Orders & Notes: Written orders by medical providers are included in the medical record. These detail the instructions given to other members of the health care team by the primary providers. The Baptist Home may not have control regarding records developed by medical providers for a resident. Therefore, The Baptist Home will not release this information unless instructed to do so by the medical provider and in accordance to law.
Nurses Notes: Updates are entered into the medical record documenting clinical changes, new information, etc. for each resident. These are entered by the licensed nursing health care team. They are kept in chronological order and document the sequence of events leading to the current state of health.

Test Results: The results of testing, such as blood tests (e.g., complete blood count) radiology examinations (e.g., X-rays), pathology (e.g., biopsy results), or specialized testing (e.g., pulmonary function testing) are included. Often, as in the case of X-rays, a written report of the findings is included in lieu of the actual film.

Other: Many other items are variably kept within the medical record. Digital images of the resident, flowsheets, informed consent forms, EKG tracings, outputs from medical devices (such as pacemakers), chemotherapy protocols, and numerous other important pieces of information form part of the record depending on the resident and his or her set of illnesses/treatments. There may be several pieces of information recorded while tracing the state of a resident’s health as ordered by the physician. including but not necessarily limited to body temperature, pulse rate (heart rate), blood pressure and respiratory rate and intake of medication, fluid, nutrition, water and blood, and output of blood, urine, excrement, vomitus and sweat. The medical record may also include notes and documents related specialties such as physical therapists, dietitians, etc.

The medical record kept by The Baptist Home is not a comprehensive record of the resident’s entire medical experience throughout a resident’s lifetime, but is comprised of only that which is relevantly acquirable and while a resident of The Baptist Home.

The Baptist Home has specific procedures for handling and releasing medical records because of the confidential information contained in the records and because of federal and state laws concerning HIV, mental health, and substance abuse information. The Baptist Home retains all rights regarding ownership of the medical records within its possession for each resident. Residents have the right to access their medical information and to control who else can have access. With some exceptions, The Baptist Home will release a copy of your records to others only with your written permission, unless required to do so by law.

PERSONS AUTHORIZED TO RELEASE MEDICAL RECORDS

Generally, only a resident can authorize the release of his or her medical records. However, there are some exceptions to the rule and generally the following can sign a release:

- Legal guardian (appointed by the court with specific powers),
- Health Care Power of Attorney and/or Durable Power of Attorney (agent selected by the resident to act on his or her behalf while he or she is still living and the resident has been declared incapacitated by the terms of the documents.)

SPECIALY PROTECTED MEDICAL INFORMATION

Federal law specially protects substance abuse treatment records. Some laws specially protect HIV/AIDS information and mental health records. These laws are meant to encourage people with these problems to get the medical treatment they need. In order to obtain a copy of these records or have them sent somewhere; a resident may need to sign a form that specifically mentions specially protected information.
DISCLOSURE WITHOUT CONSENT

Although medical records are confidential, there are times when they can be released without a resident’s consent. In special cases, records are released to:

• Health care workers and providers who have a need for the records to care for a resident.
• Qualified people or organizations that perform services such as data processing, medical record transcription, microfilming, administrative functions, or other such related services.
• Government authorities, as permitted or required by law, to investigate or regulate health related issues such as the Department of Health and Senior Services, communicable diseases, and prescription drugs.

RESPONSIBILITY OF THOSE RECEIVING MEDICAL RECORDS AND INFORMATION

Generally, strict rules apply to those who receive medical information. Responsible parties are required to have procedures to protect the resident’s confidentiality and prevent release of medical information and resident identity.

MEDICAL RECORDS AFTER A RESIDENT’S DEATH

Medical records can only be released with the written permission of the resident before death has occurred. After death, access to the medical record is limited to those who serve as an executor or trustee of the estate, authorized staff, a government authority or by a court order. The above authorities shall provide a written release exempting The Baptist Home from liability for the discharge of privately held medical information.

FEES TO COPY MEDICAL RECORDS

Residents or those whom residents have authorized may view their medical records at no charge during regular business hours in the presence of designated staff. Copies of medical records are charged at the prevailing, per-copy rate established by the Missouri Department of Health and Senior Services plus postage. A form and signed release must be completed in the Administration Office requesting the specific records to be copied. Requests may take up to 30 days to complete. Payment must be received in advance before records will be released.