2Accreditation a voluntary process of organization review in which an independent body evaluates the entity’s work pre-established criteria the act of granting weather an organization is granted approval

Acknowledgements a form that recognize receipt of important info

Ambulatory care provided on a nonresident basic in provider’s office or hospital setting

Ambulatory surgery center (ASC) has own Medicare identifier a separate entity sole purpose with surgical produres not requiring overnight stays meet requirements of MC of P

AAAASF American association for accreditation of ambulatory surgery facilities

Ancillary services test or procedures ordered by dr. to provide treatment for inpatient care

Authentication process of identifying source of health record but attaching a signature handwritten or electronic

Authorization except as otherwise specified an entity may not use or disclose health information without an authorization such use must be consistent with the authorization

Autopsy report written documation of findings of postmortem exam

CAAs care resident assessment patient accessed and recessed at prescribed intervals

Care plan goals of treatment of patient adjusted as condition requires

CMS centers for Medicare and Medicaid services oversees hipaa standards maintains the hcpcs medical code set and the Medicare remittance advice remark codes

CARF commission on accreditation of rehabilitation independent accreditor of health and human services that develops standards and accredits program

Conditions for Coverage standard applied to facilities that choose to participate in federal government programs such as Medicare and medicate

Consent to treatment legal permission given by patient or repressive that allows provider to administer care

Consultation report documentation of opinion other then primary or attending physician

Documentation standards describes the principles codes or beliefs guideline or regulations that guide health record documentation

Documents imaging electronically scanning written or printed paper documents into an optical or electronic system

Expressed consent spoken or written permission by patient to provider that allows medical treatment or surgical services

EMTALA emergency medical treatment and active labor act outlaws dumping or refusing to treat indigent emergency treatment have to provide care

Hybrid record combines paper and electronic records often common in changeover to electronic records

Joint Commission independent nonprofit organization that certifies more than 20,000 healthcare org in the USA

Legal health record documents and data that a provider may include in response to legal request for patient information

MDS minimum data set for long term care federally mandated standard assements form that Medicare and Medicaid certified nursing facilities must use to collect demographic and clinical data on residents

PAI patient assessment instrument standardized tool to evaluate patient’s condition after admission or discharge from facility

RAI resident assessment instrument in skilled nursing facilities care plan is based on a format required by federal regulations

SOAP subject object assessment plan documentation that refers to hoe each progress notes contains documentation of subject observation objective observation assessments and plans

Standing order orders the medical staff or physician has established in routine care for a specific diagnosis or producer

Statute a state or federal piece of legislation signed into law by state’s governor of the president

Transfer record review of patient’s acute stay current status discharge transfers orders and instructions that accompanies patient when transferred to another facility

Universal chart order system where patients chart is maintained in the same format while patient is in facility and after discharge

2 Maine patient and or his rep. are able to request and get copy of record in 30 days of request may be charged copying mailing fee. Records need to be kept 7 yrs. Under 18 till age 24 patient logs and x rays permanently. Found site dated Jan 2011 that me regulations do not address medical records. Federal gives access to records to patients, minors may request records HIPAA gives patient access and privacy to records and provides penalties for those who do not follow these standards. Record is currently considered to be a hybrid record. There is a list of health care workers who have access to record includes pastoral care provider, was shocked how long the list is. Records must be retained as long as state statute requires no deletion or change except in accordance with destruction policy any changes need to follow policy’s in the above voc words.

3a gives them rules and guidelines that need to be followed for records and retention. Also requires for rules for providers using Medicare and medicate payment for patients. The accrediting bodies help give guidelines to keep and make patient records. Tell how long to retain who has access how to edit records and provide a history of the patient. Also an accreditation and following these mandates can be used for legal issues that may arise.

3b A training program for all staff dealing with the importance of health records and proper way to maintain them use them and care for them. A system of checks and oversight to see the rules are being adhered to state federal as well as facility is being followed. A record system following good practices and navigation to enter keep and maintain record for patient. And a way that only those authorized have access to records.