

Medical Recordkeeping in an Occupational Health Setting

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ABSTRACT

Managing the complexity of medical recordkeeping in an occupational health setting has been compared to navigating a shadowy maze. Successful navigation requires knowledge-based clarity and direction. This article provides an overview of regulatory requirements related to medical recordkeeping in occupational health settings and highlights key medical record legislation and relevant practice standards. It discusses the importance of facility policies and procedures to recordkeeping compliance and identifies critical elements of these policies and procedures. The article identifies the range of documents included in medical recordkeeping in an occupational health setting, the primary determinants of the content, maintenance, and retention of medical records, and the medical recordkeeping tools and resources available to occupational health nurses. It provides answers to many frequently asked questions regarding recordkeeping.

Managing the complexity of medical recordkeeping in an occupational health setting has been compared to navigating a shadowy maze. Navigating successfully through the maze requires knowledge-based clarity and direction as well as attention to professional risk management. Among the elements noted in the American Association of Occupational Health Nurses, Inc. (AAOHN) Advisory “Managing Professional Risk” as decreasing the occupational health nurse’s professional risk are knowledge of the

law and how it applies to individuals’ nursing practice, adherence to professional standards of practice, and use of established policies and procedures (DiBenedetto, 1999).

This article provides an overview of regulatory requirements related to medical recordkeeping in occupational health settings and highlights key medical record legislation and relevant practice standards. The author discusses the importance of facility policies and procedures to recordkeeping compliance and identifies critical elements of these policies and procedures. The article addresses the following key elements: the scope of occupational health medical recordkeeping; definitions and required content of employee medical records; confidentiality and access to medical records; and record retention requirements. It identifies the range of documents included in medical recordkeeping in an occupational health setting, the primary determinants of the content, maintenance, and retention of medical records, and the medical recordkeeping tools and resources available to occupational health nurses. Responses to several frequently asked questions are also provided. Consid-

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eration is given to future trends and needs in medical recordkeeping.

SCOPE OF MEDICAL RECORDKEEPING IN OCCUPATIONAL HEALTH

What is covered by the phrase *medical recordkeeping in occupational health*? First, medical recordkeeping includes employee medical records and all their elements: how they are defined, their content and format, record confidentiality, access to the records, and how and for how long records need to be maintained. The phrase can also include employee-submitted claim forms, illness and injury logs, and reporting documents required of employers.

In the occupational health setting, medical recordkeeping is subject to three principal determinates: professional practice legislation and standards; federal legislation; and state legislation. Key to managing these elements effectively is identifying their relevance for the occupational health nurse's individual facility and documenting the applicable elements along with processes for compliance in the facility's policy and procedure manual.

According to AAOHN, "Policy and procedures (P&P) serve as the foundation of a company's or organization's occupational health service and, therefore, are integral to the role of the occupational health nurse" (AAOHN, 2009, p. 261). Well-written policies and procedures that are followed by facility practitioners save time, provide practice consistency, guide responses to issues and difficult situations, and reduce professional risk. When developing policies and procedures for medical recordkeeping in occupational health, the first priority is to identify applicable legislation and standards based on the characteristics of the facility, the practitioners, the services provided, and the population served. For example, facility location and the location(s) of the services provided determine applicable state legislation; industry and job requirements of the worker population determine applicable occupational health legislation; and roles and tasks of the facility practitioners determine applicable practice legislation and standards.

Many of the questions that arise regarding medical recordkeeping in occupational health are more often questions about process than about specific regulatory requirements. Appropriate answers to process questions (e.g., How should the occupational health nurse respond when "corporate" or "legal" requests an employee medical record?) require review and discussion of several elements, including the legislation governing the record requested, the purpose of the request, the content required to meet that purpose, and the development of procedures to accomplish the smooth transfer of appropriate records. Thoughtfully constructed procedures should document the processes to be followed by the occupational health nurses at the facility when responding to requests for medical records.

Facility electronic medical recordkeeping processes should be documented along with more common paper record systems. Although technical documentation usually accompanies the electronic system, facility practitioners may require more detailed guidance to ensure

accuracy and consistency in recordkeeping. Policies and procedures must be signed, dated, and readily accessible to facility practitioners. Periodic review is a necessity and regular self-audit ensures that the procedures accurately reflect current practice.

PROFESSIONAL PRACTICE LEGISLATION AND STANDARDS

The legislation and standards that govern professional practice are a basic component of the determinates of medical recordkeeping. Many states have specific requirements for documenting professional activities in their Nurse Practice Acts (NPAs) and in the Board of Nursing (BON) legislative rules and regulations. For example, both the West Virginia and the Tennessee NPAs include the "accurate recording of facts" in their definitions of the practice of registered nurses (West Virginia Nurse Practice Act, 2009, §30-7-1.(b)) and professional nursing (Tennessee Nurse Practice Act, 2009, §63-7-103.(a)(1)). Rules and regulations of the Wisconsin BON include the "recording of symptoms and reactions" in their definition of professional nursing (Wisconsin Statutes, 2009, 441.001(4)(a)).

State NPAs and BON rules and regulations may also reference standards for nursing practice that include recordkeeping elements. For example, a required step in the nursing process described in the Maryland BON Standards of Care for professional nurses is that, "Relevant health status data, including changes, shall be documented in an authorized record which is accessible and in a retrievable form" (Maryland Code, 2009, §10.27.09.02). The Pennsylvania NPA Standards of Nursing Conduct require that the registered nurse, "Safeguard . . . the confidentiality of patient information . . ." and also "Document and maintain accurate records" (Pennsylvania Code, 2009, §21.18.(a)(5)). The Legal Standards of Practice for Registered Professional Nurses in West Virginia require that the nurse ". . . document nursing assessments . . ." (West Virginia Code, 2009, §19-10(1)). Other states may incorporate professional standards of practice specifically, as in Kentucky's BON regulations in which American Nurses Association and American Academy of Nurse Practitioners practice standards are included in the scope and standards of practice for advanced registered nurse practitioners (Kentucky Administrative Regulations, 2009). Or, the legislation may require that the nurse conform to "acceptable standards of practice," as in the Connecticut NPA, which defines improper professional conduct, in part, as "conduct which fails to conform to the accepted standards of nursing practice" (Connecticut Nurse Practice Act, 2009, §20-99a). Acceptable practice standards may be found in the practice standards developed by the professional associations. These, almost without exception, include stated recordkeeping criteria. The Standards of Occupational and Environmental Health Nursing developed by AAOHN require that data be documented, retrievable, and confidential (AAOHN, 2004). According to the AAOHN Core Curriculum, all clinical encounters must be documented appropriately (e.g., legible, complete, dated, signed, permanent) (Salazar, 2001).

Although the use of abbreviations on the Joint Commission's "Do Not Use" list (Joint Commission, 2009) is to be avoided, any reasonable approach to standardizing abbreviations is acceptable (e.g., listing standardized abbreviations developed for use by the facility) (Joint Commission, 2008). The Code of Professional Conduct issued by the Commission for Case Manager Certification (2009) requires confidential records of client services.

State nursing legislation may include other requirements related to documentation and recordkeeping (e.g., documentation of continuing education, nurse practitioner protocols or cooperative agreements, and approvals for immunization protocols). It is critically important that occupational health nurses be familiar and comply with the nursing practice legislation in the state(s) where they provide nursing services.

Additionally, other state agencies may have recordkeeping requirements for health professionals practicing in the state. For example, the medical records section of the Connecticut Public Health Code requires state licensed or certified practitioners to "maintain appropriate records of the assessment, diagnosis, and course of treatment provided each patient and such medical records shall be kept for the period prescribed" (Connecticut Public Health Code, 2009, §19a-14-41). States may have requirements for professional practitioners to report certain diseases, injuries, or illnesses, including infectious diseases and incidents of abuse. The examples of state legislation addressed above are only those related to documentation in general professional practice. A later section addresses state legislation and agencies specific to occupational health.

FEDERAL AGENCIES AND LEGISLATION

Many federal agencies and legislation have applicable requirements for medical recordkeeping in occupational health. Among these, several warrant specific attention:

- Occupational Safety and Health Administration (OSHA).
- Department of Transportation (DOT).
- Family and Medical Leave Act (FMLA).
- Americans with Disabilities Act (ADA).
- Health Insurance Portability and Accountability Act (HIPAA).
- Genetic Information Nondiscrimination Act (GINA).
- National Childhood Vaccine Injury Act (NCVIA).

In the author's experience, these agencies and legislation generate the most questions from occupational health nurses. However, these agencies and legislation may not all be applicable at a particular facility. As with the professional practice legislation, applicability depends on the characteristics of the facility, its practitioners, the services provided, and the population served. This section highlights key recordkeeping requirements in each of the agencies and for each legislative act listed and also addresses relevant guidelines issued by regulatory agencies.

OSHA

From a recordkeeping perspective, three main groups of OSHA standards should be considered: 29 CFR

§1904 Recording and Reporting Occupational Injuries and Illness; 29 CFR §1910.1020 Access to Employee Exposure and Medical Records; and each of the standards in 29 CFR §1910 with medical screening and surveillance requirements. The latter two standards are General Industry Standards (29 CFR §1910). If services are provided to workers in specified industries (e.g., agriculture, shipyard, marine terminals, construction), other industry-specific standards may also apply. From a recordkeeping perspective, these industry-specific standards are generally comparable to the General Industry Standards discussed here, but need to be reviewed by the occupational health nurse where applicable.

29 CFR §1904 Recording and Reporting Occupational Injuries and Illness. Injury and illness recordkeeping is the standard that most frequently comes to mind when OSHA recordkeeping requirements are discussed and it is a standard that generates numerous questions from occupational health nurses. The standard applies across industries to all employers covered by the Occupational Safety and Health Act. Employers with fewer than 10 employees or businesses in certain industry classifications are partially exempt from the standard and are not required to keep OSHA injury and illness records unless informed in writing by OSHA or the Bureau of Labor Statistics (BLS) that they must. Partially exempt industries are listed by Standard Industry Classification (SIC) code in 1904 Subpart B Appendix A. All employers, including those with partial exemption, must report workplace incidents that result in fatalities or the hospitalization of three or more employees. The regulatory text documented on the OSHA website includes explanatory questions and answers that provide compliance guidance. Additional assistance is provided in the OSHA Recordkeeping Handbook, a summary document that includes policy, frequently asked questions, and letters of interpretation (OSHA, 2005). In that summary of the injury and illness recordkeeping standard, relevant sections of the standard are noted in parentheses; the text of each section can be accessed through the links on the standard's table of contents webpage (OSHA 29 CFR §1904).

The Sidebar highlights the basic requirements of the standard. Among the nine specified exemptions (1904.5(b)(2)) to the presumption of work-relatedness for injuries and illness resulting from events or exposures occurring in the work environment are injuries or illnesses resulting solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity such as blood donation, physical examination, flu shot, exercise class, racquetball, or baseball. Also among the specified exemptions are injuries and illnesses that are caused by a motor vehicle accident and occur on a company parking lot or company access road while the employee is commuting to or from work. Injuries and illnesses that occur while an employee is on travel status are work-related if, at the time of the injury or illness, the employee was engaged in work activities "in the interest of the employer" (1904.5(b)(6)). The standard specifies two exceptions when injuries or illnesses that occur when the employee is on travel status do not have to be recorded and provides

Injury and Illness Recordkeeping Basic Requirements (OSHA 29 CFR §1904)

- The standard requires employers to record each fatality, injury, and illness that:
 - is work-related (1904.5); *and* is a new case (1904.6) *and* meets one or more of the general recordkeeping criteria (1904.7) *or* criteria applied to specific cases (1904.8-11)
- Injuries and illnesses are considered work-related if:
 - an event or exposure in the work environment caused or contributed to the resulting condition *or* significantly aggravated a preexisting injury or illness
- Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment, unless an exception specified in 1904.5(b)(2) applies.
- Work-related injury and illness cases are considered new if:
 - the employee has not previously experienced a recorded injury or illness of the same type that affects the same part of the body (1904.6(a)(1)) *or* the employee had a prior recordable illness or injury of the same type affecting the same body part but had completely recovered (all signs and symptoms had disappeared) (1904.6(a)(2)).
- The injury or illness is considered to meet the general recording criteria if:
 - it results in death, days away from work, restricted work, or transfer to another job, medical treatment beyond first aid, or loss of consciousness *or* it involves significant injury or illness diagnosed by a physician or other licensed health care professional, even if the injury or illness does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness (1904.7(a)).
- Recordable injuries and illnesses must be logged on the Occupational Safety and Health Administration (OSHA) 300 log for:
 - all employees on the employer's payroll *and* employees not on the employer's payroll if they are supervised by the employer on a day-to-day basis (1904.31).
- Each injury or illness must be recorded on the OSHA 300 log and 301 Incident Report within 7 calendar days of receiving information that the recordable injury or illness has occurred (1904.29(b)(3)).
- The OSHA 300 log must be reviewed at the end of each calendar year to verify that entries are complete and accurate and to correct any deficiencies that are identified (1904.32(a)).
- An annual summary of recorded injuries and illnesses must be compiled, certified by a company executive, and posted in a conspicuous place or places where notices to employees are customarily posted (1904.32(a)(1-4)).
- The retention period for the OSHA log, the privacy case list, the annual summary, and the OSHA 301 Incident Report forms is 5 years (1904.33).
- During the retention period, stored OSHA 300 logs must be updated to include newly discovered recordable injuries and illnesses and to show any changes that have occurred in the classification of previously recorded injuries and illnesses. Stored annual summaries do not need to be updated.

specific guidance to use in determining work-relatedness (1904.5(b)(6)(i-ii)). Although seasonal flu is among the listed exemptions to the presumption of work-relatedness for injuries and illness resulting from events or exposures occurring in the work environment, a 2009 OSHA compliance directive stated that the seasonal flu work-relatedness exemption did not apply to 2009 H1N1 cases. Confirmed H1N1 cases that are determined to be work-related as defined by 1904.5 and meet the recording criteria of 1904.7 must be recorded (OSHA, 2009a).

The standard provides a complete list of all treatments (13 are listed) that, regardless of the professional status of the person providing them, are considered first aid (1904.7(b)(5)(ii)). These are the only treatments that are considered first aid for the purpose of meeting the recordability standard. Also, specific recordability criteria apply to work-related cases of needlestick and sharps injuries (1904.8), cases involving medical removal under OSHA

standards (1904.9), occupational hearing loss (1904.10), and work-related tuberculosis cases (1904.11). When these work-related injuries or illnesses occur, the occupational health nurse must use the applicable recordability criteria. Where privacy is a concern (1904.29(b)(6)), the employee's name may not be entered on the OSHA 300 log; "privacy case" is entered instead. A separate, confidential list of employee names and case numbers must be maintained so that cases can be updated as needed and information provided to the government when requested.

Computerized records are permitted, provided that equivalent forms can be produced when needed (1904.29(b)(5)). An electronic signature can be used to certify the annual summary, but a copy of the annual summary must be printed and posted no later than February 1 through April 30 (OSHA, 2009b).

OSHA Standards Having Medical Screening and Surveillance Requirements. OSHA's medical screening

and surveillance webpage (OSHA, 2009c) highlights 30 General Industry Standards that address medical screening and surveillance, including 29 CFR §1910.120 Hazardous Waste Operations and Emergency Response, 29 CFR §1910.134 Respiratory Protection, and the 29 CFR §1910 Subpart Z, Toxic and Hazardous Substances Standards (e.g., 1910.01 Asbestos, 1910.25 Lead, 1910.1028 Benzene, and 1910.1030 Bloodborne Pathogens). Each of the 30 standards includes medical recordkeeping requirements; at a minimum the requirement is for an accurate record of the required medical evaluation and compliance with 29 CFR §1910.1020 Access to Employee Exposure and Medical Records. Many standards additionally require that the employee medical record include information such as:

- The employee's name and Social Security number.
- A copy of the information required by the standard to be provided to the physician or other health care provider (e.g., employee's job description, exposures, personal protective equipment, prior medical examinations).
- A copy of the physician's or other licensed health care provider's written opinion (e.g., ability to wear a respirator or any detected medical conditions that would place the employee at increased risk of material impairment of the employee's health from work, any work limitations, or a statement that the employee was informed of the evaluation results).

The recordkeeping section of each applicable standard must be reviewed by the occupational health nurse to determine the details of the recordkeeping requirements for that standard.

In addition to requiring that a medical record be established for each employee with occupational exposure as defined by the standard and that confidentially be maintained, the Bloodborne Pathogens standard requires that an exposure control plan be developed and documented (1910.1030(c)(1)(i)), that training be documented (1910.1030(h)(2)), and that a Sharps Injury Log be maintained for the recording of percutaneous injuries from contaminated sharps (1910.1030(h)(5)). The OSHA 300 log can be used for the required sharps injury log, provided that the employee's confidentiality is protected, the sharps information can be easily segregated from other injuries and illnesses, and information about the type and brand of the device involved in the incident is added to the form (OSHA, 2005).

The standard specifies the content of the medical record, requiring that it include:

- The name and Social Security number of the employee.
- A copy of the employee's hepatitis B vaccination status, including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination.
- A copy of all results of required examinations, medical testing, and follow-up procedures.
- The employer's copy of the health care professional's written opinion.
- A copy of the information provided to the health care professional (1910.1030(h)(1)(ii)).

29 CFR §1910.1020 Access to Employee Exposure and Medical Records. The standard applies to general industry, maritime, and construction employers who make, maintain, contract for, or have access to employee exposure or medical records, or analyses of medical records, pertaining to employees exposed to toxic substances or harmful physical agents.

Key elements of OSHA's Access to Employee Exposure and Medical Records standard for occupational health nurses are the definition of medical records and the requirements related to access to records, to employee information, and to record maintenance and retention. These elements are summarized in the Sidebar.

Routinely discarded physical specimens are not included in the definition of employee medical records. Also excluded are records concerning health insurance claims or voluntary employee assistance programs if maintained separately from the occupational health program and its records and not accessible to the employer by direct personal identifier. Records created solely in preparation for litigation that are privileged from discovery are also excluded.

Other than the requirement to maintain chest x-rays in their original state, the standard does not mandate how records are maintained, provided the necessary information is preserved and retrievable (1910.1020(d)(2)). When electronic recordkeeping systems are used, data fields must be adequate, providers and recorders identifiable, and data accessible when needed. Although first aid records are included in the definition of employee medical records, these records are excluded from the retention requirements if they are:

- Records of one-time treatment and subsequent observations of minor non-recordable hurts.
- Made on-site by a non-physician.
- Separately maintained from the medical program and records (1910.1020(d)(1)(i)(B)).

Facility policy would govern how long first aid logs and records not considered medical records are maintained. Usual practice is to keep them for 5 years, the same as the injury and illness recordkeeping required update period. The medical records of employees who have worked for less than (1) year for the employer need not be retained beyond the term of employment if they are provided to the employee upon the termination of employment (1910.1020(d)(1)(i)(C)).

In addition to the requirement that employers notify employees about the existence of medical records, the standard stipulates various processes and limitations that may apply to requests for access to employee medical records or when information in the medical record requires special treatment (1910.1020(e)(1)(ii)-(vi) and (2)). Access to employee medical records by OSHA is addressed in the standard (1910.1020(e)(3)); practices and procedures used by OSHA when access to employee medical records is sought are found in 1913.10.

The standard requires that records be transferred to successive owners when the employer ceases to do business. If there is no successive owner, the standard details the process to be followed for employee and

Summary of Key Requirements of 29 CFR §1910.1020 Access to Employee Exposure and Medical Records for Occupational Health Nurses

- Employee medical record means a record concerning the health status of an employee that is made or maintained by a physician, nurse, or other health care personnel, or technician (1910.1020(c)(6)(i)), including:
 - medical and employment questionnaires or histories (including job descriptions and occupational exposures)
 - results of medical examinations and laboratory tests
 - first aid records
 - medical opinions, diagnoses, progress notes, and recommendations
 - descriptions of treatments and prescriptions
 - employee medical complaints
- The standard requires that employees be notified at employment and annually of the existence, location, and availability of their records, the person responsible for maintaining the records, and the employee's right to access these records (1910.1020(g)).
- When requested by an employee or designated representative (with the employee's specific written consent), access to the employee's medical records must be provided in a reasonable time (generally within 15 days), place, and manner ((1910.1020(e)(1)(i)).
- The standard requires that employee medical records be preserved and maintained for the duration of employment plus 30 years (1910.1020(d)(1)(i)).
- The standard also requires that records be transferred to successive owners when the employer ceases to do business (1910.1020(h)(1)).

OSHA notification and transfer or disposal of records (1910.1020(h)(2)-(4).

DOT

The documentation and recordkeeping requirements of the DOT fall into two major categories: medical examinations and certifications; and drug and alcohol testing. Recordkeeping requirements are uniquely specified by each of the DOT agencies, although some standardization exists across agencies from the DOT Office of Drug & Alcohol Policy & Compliance (ODAPC) for drug and alcohol testing records. Medical examinations or medical certifications are required by several of the DOT agencies, including the Federal Aviation Administration (FAA), the Federal Motor Carrier Safety Administration (FMCSA), the Federal Railroad Administration, and the Pipeline and Hazardous Materials Administration (PHMSA). Occupational health nurses providing services to employees subject to one of the DOT agency's medical requirements should review the specific agency's regulations regarding documentation and recordkeeping. For example, the FAA requires the examining physician to send completed aviation medical examinations electronically to the FAA within 14 days, mail the original copy, and retain the work copy for at least 3 years (FAA, 2007). For commercial motor vehicle medical examinations, FMCSA requires the medical examiner to retain a copy of the commercial motor vehicle medical examination report for at least 3 years from the date of examination (FMCSA, 2008).

Recordkeeping requirements related to DOT drug and alcohol testing programs are documented in 49 CFR Part 40 and also in industry-specific regulations (airline, motor carrier, railroad, transit, pipelines, and maritime). The ODAPC publication "Employer Record Keeping Requirements for Drug & Alcohol Testing Information" (ODAPC, 2009) provides an overview of requirements, but the relevant regulations also need to be reviewed by the occupational health nurse. Generally, the regulations require that records be created and maintained for administrative elements (e.g., testing process, equipment calibration, return-to-duty processes), test results, and employee and supervisor training. Retention periods for the document elements vary by element from 1 year (e.g., negative drug test results) to 5 years (e.g., verified positive drug tests) as well as by transportation industry. In some cases, an annual management information system report must be submitted and retained. Although records can be maintained electronically, DOT requires that paper files be kept (ODAPC, 2009). Where required, the annual management information report can be submitted electronically. Drug and alcohol test records must be maintained securely with controlled access; electronic test records should be password protected.

FMLA and ADA

Both the Family and Medical Leave Act and the Americans with Disabilities Act require that relevant medical records be maintained confidentially and separately from employment records. Records and documents

created for the purposes of FMLA that relate to certifications, recertifications, or medical histories of employees or employees' family members must be maintained as confidential medical records (FMLA, 2009, §825.500(g)). ADA requires that information regarding the applicant's medical condition or history be maintained on separate forms and in separate medical files and be treated as a confidential medical record (Equal Employment Opportunity Commission, 2008). The record retention requirement is at least 3 years for FMLA (825.500(b)) and 1 year for ADA.

HIPAA

The Health Insurance Portability and Accountability Act, administered by the Department of Health and Human Services, Office of Civil Rights (OCR), generates numerous questions from occupational health nurses. Because the HIPAA regulations apply only to covered entities, the most important question is: Is the facility a covered entity? Covered entities can be health plans, health care clearinghouses, or health care providers, if they are transmitting health information in electronic form in connection with a covered transaction. Although determining if the occupational health unit is a covered entity can be complex, the OCR website provides detailed guidance to assist facilities in doing so. If the occupational health nurse's facility is considered a covered entity, then the occupational health nurse must be knowledgeable about HIPAA regulations, including the definition of protected health information, protecting individually identifiable health information, allowable uses and disclosures of protected health information, and HIPAA-required policies and procedures. For the average health care provider or health plan, the Privacy Rule (the regulations implementing HIPAA) requires activities such as:

- Notifying patients about their privacy rights and how their information can be used.
- Adopting and implementing privacy procedures.
- Training employees so they understand the privacy procedures.
- Designating an individual to be responsible for seeing that the privacy procedures are adopted and followed.
- Securing patient records containing individually identifiable health information so the records are not readily available to those who do not need them (HIPAA, 1996).

HIPAA is not a barrier to workers' compensation or to quality assurance or certification review. As with all allowable disclosures and permitted uses of protected health information, the basic principle of "minimal necessary" applies and required procedures must be followed.

GINA

The Genetic Information Nondiscrimination Act, enacted in 2008, protects individuals against discrimination based on their genetic information in health insurance coverage (Title I) and in employment (Title II). GINA defines genetic information as including information from genetic tests, the genetic tests of family members, family medical history, and genetic information of a fetus carried by an individual or an individual's family member or an

embryo lawfully held by an individual or family member receiving assistive reproductive services. Genetic information also includes information about an individual's or family member's request for or receipt of genetic services (GINA, 2008). The inclusion of family medical history in the definition of genetic information can be an issue for occupational health nurses when occupational health risk assessments and disease management and wellness programs collect genetic information from benefit plan participants and beneficiaries. HIPAA-covered entities are reminded that genetic information is considered health information subject to the requirements of the Privacy Rule. According to Litchfield (2009), "GINA increases employer responsibility to ensure individual and family health history information within employees' records remains confidential and is not used to impact workers' employment or their access to health insurance" (p. 439).

NCVIA

Despite its name, the National Childhood Vaccine Injury Act applies to practitioners administering a covered vaccine to adults as well as to children (Centers for Disease Control and Prevention [CDC], 2006). Covered vaccines include diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis B, *Haemophilus influenzae* type b, influenza, pneumococcal conjugate, meningococcal, rotavirus, human papillomavirus, and varicella (chickenpox). NCVIA requires administering health care providers to provide a copy of the relevant current edition of the Vaccine Information Sheet (VIS) and to ensure that a record is made in the recipient's permanent medical record (or a permanent office log or file). The record must include:

- The date the vaccine was administered.
- The vaccine manufacturer and lot number.
- The name, address, and title of the person administering the vaccine.
- The edition date of the VIS distributed and the date it was provided.

Although not required, recording the vaccine dose and site is a best practice. Documentation of consent is not required by NCVIA, but can be recommended or required by certain state or local authorities. NCVIA does require the provider to report vaccine adverse reactions through the Vaccine Adverse Event Reporting System (VAERS). The VAERS website provides a Reportable Events Table that identifies the events specific to each vaccine (e.g., anaphylaxis, encephalitis, contraindications to a following dose) that are to be reported (VAERS, 2008).

Other Federal Legislation

The preceding discussion of federal legislation does not cover all possible elements that may be applicable to a particular occupational health facility. Characteristics of the facility, the provider, the population served, and the services provided may determine that the recordkeeping requirements of other federal legislation are relevant. For example, facilities with on-site laboratories may be subject to the recordkeeping requirements of the Clinical Laboratories Improvement Amendments (CLIA); or

facilities providing services to employees in the chemical industry may be subject to the recording and reporting requirements of the Toxic Substance and Control Act (TSCA). Federal agencies also publish guidelines that may be applicable and contain recordkeeping practices; they should be reviewed by the occupational health nurse. The CDC website (CDC, 2010) provides links to several guidelines relevant for health care professionals, such as the “Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post-Exposure Prophylaxis—2005.”

STATE LEGISLATION

The third component governing medical recordkeeping in occupational health is state legislation. Occupational health nurses need to be knowledgeable about the regulatory requirements of the state(s) in which they practice. The official web portal of the U.S. government (www.usa.gov) provides links to all the state government websites. For occupational health nurses, the state Department of Labor (DOL) is generally the agency with the most applicable recordkeeping requirements. The state DOL is usually the agency responsible for occupational health and safety, injury and illness reporting, and workers’ compensation. States having OSHA-approved state plans (currently 24 states, Puerto Rico, and the Virgin Islands) must have recordkeeping requirements that are at least identical to the federal OSHA standards. States may have worker injury and illness reporting requirements that are more expansive or more stringent than the federal standard and they may also have other relevant legislation. The state of Connecticut, for example, requires that employee health facilities be licensed and the governing regulations include recordkeeping requirements (Connecticut General Statutes, 2009).

The workers’ compensation process offers many opportunities for documentation and recordkeeping. Although this process is primarily within state jurisdiction, the federal government also administers four major disability compensation programs: federal and postal employees; Department of Energy employees; longshoremen and harbor workers; and coal miners disabled by black lung disease (U.S. DOL, 2009). State programs are generally governed by a state workers’ compensation act and administered by a workers’ compensation commission. The specific requirements and forms for workers’ compensation programs vary by state, but generally the process requires three types of documentation: a report of the injury, a notice of claim, and medical reports. Although the workers’ compensation process requires the transfer of medical information, confidentiality principles still apply. It is essential that only medical information related to the workers’ compensation condition be transmitted. In many states, the employee’s filing of the workers’ compensation claim form is viewed as authorization for the release of relevant medical information. Other states require specific authorization. HIPAA is not a barrier to workers’ compensation, but the occupational health nurse must remember that “minimum necessary” is the Privacy

Rule standard. Several states include regulations regarding medical case management and may have additional documentation and recordkeeping requirements.

The state DOL may also administer state FMLA-type legislation that may be comparable to the federal legislation or have additional requirements. Other state agencies may also have documentation and recordkeeping requirements that are relevant for the occupational health nurse. As noted previously, states generally have requirements for infectious disease reporting administered by a public health or health and safety department. State emergency response management agencies may also have recordkeeping requirements applicable to an occupational health facility. Local management of medical waste is generally a state function, administered by an environmental or hazardous waste management agency. State medical waste management regulations usually include documentation and recordkeeping requirements that may be applicable to generators of even small quantities of medical waste, such as occupational health clinical facilities.

For the most part, towns, municipalities, and other local government agencies do not have recordkeeping requirements applicable to occupational health settings, but this is something the occupational health nurse should verify through local authorities.

ELECTRONIC RECORDKEEPING

The future of medical recordkeeping is electronic. A national network of electronic health records is being viewed as a way to improve the quality of care, improve patient safety, and lower costs. Electronic medical records have become increasingly important. Currently, the national focus is on records generated in government programs (e.g., Medicare, Medicaid), but seamless integration over time with other insurers and providers is not a farfetched vision. A proliferation of online health history and health record forms has already appeared, along with the development and implementation of personal health and occupational health electronic recordkeeping systems. It is critical that occupational health nurses be prepared for the future. They must establish documentation best practices. They must pay attention to regulatory requirements and documentation needs. They must consider how those requirements and needs can be met electronically.

RECOMMENDATIONS FOR OCCUPATIONAL HEALTH NURSING PRACTICE

The professional practice of occupational health nurses includes a responsibility for “maintaining a current knowledge of the laws affecting occupational health practice in the jurisdiction where they practice” (Knoblauch, Childre, & Strasser, 2001, p. 73). Managing the complex legislation and standards for medical recordkeeping in an occupational health setting can be a challenge for the occupational health nurse. Using a process such as the one listed below can meet that challenge:

1. Identify applicable legislation and standards.
2. Review legislation and standards, noting relevant elements.

IN SUMMARY

Medical Recordkeeping in an Occupational Health Setting

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- 1 Although medical recordkeeping in an occupational health setting is complex, with the relevant knowledge, it can be effectively managed by the occupational health nurse.
- 2 Medical recordkeeping includes employee medical records and their content, format, privacy, access, and retention. It can also include employee-submitted claim forms and the illness and injury logs and reporting documents required of employers.
- 3 Medical recordkeeping in an occupational health setting is governed by professional practice legislation and standards, by federal legislation, and by state legislation. Occupational health nurses must determine which elements from this broad range of requirements are applicable at their facility and document relevant recordkeeping processes in the facility's policy and procedure manual.

3. Develop and document policies and procedures to ensure compliance.

4. Review and update periodically.

The principal determinates of needed elements for medical recordkeeping in occupational health are found in professional practice legislation and standards, in federal legislation, and in state legislation. Identification of legislation and standards applicable for the individual facility is based on the characteristics of the facility, the practitioners, the services provided, and the population served. Documentation by occupational health nurses of applicable medical recordkeeping requirements along with processes for compliance in facilities' policy and procedure manuals supports regulatory compliance and responsible professional practice.

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Medical Recordkeeping in an Occupational Health Setting

This issue of the AAOHN JOURNAL contains a Continuing Nursing Education Module on "Medical Recordkeeping in an Occupational Health Setting." 1.0 contact hour of continuing nursing education credit will be awarded by AAOHN upon successful completion of the posttest and evaluation.

A certificate will be awarded and the scored test will be returned when the following requirements are met by the participant: (1) The completed answer sheet is received at AAOHN on or before November 30, 2011; (2) A score of 70% (7 correct answers) is achieved by the participant; (3) The answer sheet is accompanied by a check or money order for \$15.00 (\$20.00 non-members), or purchase online for \$10.00 (\$15.00 non-members) at www.aoahn.org. Expect up to 4 weeks for delivery of the certificate.

Upon completion of this lesson, the occupational health nurse will be able to:

1. Identify the scope, required content, and maintenance of medical recordkeeping in occupational health settings.
2. Describe the primary determinants of the content, maintenance, and retention of occupational health medical records.
3. List key medical record legislation, relevant practice standards, and resources available to occupational health nurses for occupational health medical recordkeeping.

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Contact hour credits received for successful completion of the posttest and evaluation may be used for relicensure, certification, or re-certification.

Directions: Circle the letter of the best answer on the answer sheet provided. (Note: You may submit a photocopy for processing.)

1. When developing policies and procedures for medical recordkeeping in occupational health, the occupational health nurse prioritizes which of the following determinates?

- A. Identification of applicable legislation and standards based on characteristics of the facility, the practitioners, services provided, and populations served.
- B. Federal legislation.
- C. Professional practice legislation and standards.
- D. State legislation.

2. Each injury or illness must be logged on the Occupational Safety and Health Administration (OSHA) 300 log and 301 Incident Report within ___ days of receiving information that the injury or illness has occurred.

- A. 3.
- B. 5.
- C. 7.
- D. 10.

3. An injury or illness meets the general recording criteria if it results in any of the following except:

- A. Days away from work.
- B. First aid.
- C. Restricted work.
- D. Loss of consciousness.

4. The retention period for the OSHA log, privacy case list, annual summary, and OSHA 301 Incident Report forms is how many years?

- A. 3.
- B. 4.
- C. 5.
- D. 6.

5. When an employee or designated representative requests medical records and provides written consent, the access to the medical records must be provided

in a reasonable time (usually within ___ days).

- A. 11.
- B. 13.
- C. 15.
- D. 17.

6. Employees' medical records must be preserved and maintained for the duration of employment plus ___ years.

- A. 10.
- B. 20.
- C. 25.
- D. 30.

7. The Federal Aviation Administration requires the examining physician to send completed aviation medical examinations electronically within ___ days.

- A. 12.
- B. 14.
- C. 16.
- D. 18.

8. The record retention requirement for the Americans with Disabilities Act is how many years?

- A. 1.
- B. 2.
- C. 3.
- D. 4.

9. As required by the National Childhood Vaccine Injury Act, the occupational health nurse must record all but which of the following?

- A. Date the vaccine was given.
- B. Vaccine dose.
- C. Name, address, and title of person administering the vaccine.
- D. Vaccine manufacturer and lot number.

10. Generally, the state agency with the most applicable recordkeeping requirements for the occupational health nurse is which of the following?

- A. State Department of Labor.
- B. State Department of Transportation.
- C. State Department of Agriculture.

Medical Recordkeeping in an Occupational Health Setting

December 2010

(Goal: To gain ideas and strategies to enhance personal and professional growth in occupational health nursing.)

Mark one answer only!

(You may submit a photocopy of the answer sheet for processing.)

- | | |
|------------|------------|
| 1. A B C D | 6. A B C D |
| 2. A B C D | 7. A B C D |
| 3. A B C D | 8. A B C D |
| 4. A B C D | 9. A B C D |
| 5. A B C D | 10. A B C |

EVALUATION (must be completed to obtain credit)

Please use the scale below to evaluate this continuing education module.

	4 - To a great extent	3 - To some extent	2 - To little extent	1 - To no extent
1. As a result of completing this module, I am able to:				
A. Identify the scope, required content, and maintenance of medical recordkeeping in occupational health settings.	4	3	2	1
B. Describe the primary determinants of the content, maintenance, and retention of occupational health medical records.	4	3	2	1
C. List key medical record legislation, relevant practice standards, and resources available to occupational health nurses for occupational health medical recordkeeping.	4	3	2	1
2. The objectives were relevant to the overall goal of this independent study module.	4	3	2	1
3. The teaching/learning resources were effective for the content.	4	3	2	1
4. How much time (in minutes) was required to read this module and take the test?	60	70	80	90

Please print or type: (this information will be used to prepare your certificate of completion for the module).
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