

STATE OF OKLAHOMA

1st Session of the 44th Legislature (1993)

HOUSE BILL NO. 1702

By: Johnson (Rob)

AS INTRODUCED

An Act relating to hospitals; specifying general requirements of hospital medical records; providing general record content requirements; specifying requirements governing surgery records, obstetrical records and newborn records; providing requirements for medical records for outpatient services, emergency room services and observation services; providing medical record requirements for psychiatric records; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-722 of Title 63, unless there is created a duplication in numbering, reads as follows:

The following requirements shall govern hospital medical records:

1. A medical record shall be maintained for each patient admitted for care in a hospital;
2. The original or a copy of the original, when the original is not available, of all reports shall be filed in the medical record;

3. The record shall be permanent and shall be either typewritten or legibly written in ink;

4. All dictated reports shall include the date of dictation and the date of transcription;

5. Medical record transcription shall be timely. Current records including, but not limited to, history and physical examinations, progress notes, consultation reports, operative notes and radiology reports, shall be transcribed within at least forty-eight (48) hours of dictation;

6. Only standard abbreviations approved by the hospital medical staff shall be used. The list of abbreviations shall be reviewed annually and revised, if necessary;

7. Errors shall be corrected by drawing a single line through the incorrect data, labeling it as "Error", initialing and dating the entry;

8. All entries into the medical record shall be authenticated by the source of the information. History and physical examinations and discharge summaries completed by medical students or residents must be signed by the student or resident and cosigned by the attending physician. The attending physician shall sign the medical record with his first initial, last name and title on either the admitting orders or initial progress note. Other authorized personnel shall sign their first initial, last name and title at least once per page and then may initial their entries thereafter. Electronic or computer-generated signatures are acceptable as authentication if the signature is generated by a confidential code which only the user possesses. The purpose of signature authentication is to assure that the information in the medical record is reliable and to correctly place responsibility for orders, assessments and reports. The safeguards provided in paragraph 9 of this section for the use of rubber stamps should be adhered to for the use of electronic signatures;

9. A physician, not his assistant, secretary or any hospital or private office personnel, may be permitted to use a rubber stamp signature, if this method is approved in writing by the hospital administrator and Medical Record Committee of the hospital, and if proper safeguards are made. Proper safeguards include:

- a. a signed statement by the physician, filed in the administrator's office, stating that he will use a rubber stamp on his hospital records and the signature stamp will be in his possession at all times or locked in the hospital's Medical Record Department when not in use by the physician,
- b. the signature stamp shall be the full, legal name of the physician and include his professional title,
- c. permanent blue or black ink is acceptable for use in the medical record,
- d. the signature stamp may be used in any place in the medical record where a legal physician signature is required, and
- e. physicians shall review the information before affixing the signature stamp to the record;

10. Standardized or preprinted medical reports shall not be used;

11. The patient's medical record shall be complete and contain all required signed documentation, including physician reports, no later than thirty (30) days following the patient's discharge date;

12. Disease, operation and physicians' indices shall be maintained by manual, abstract or computer means. Records shall be indexed within three (3) months following discharge;

13. Records of discharges shall be coded in accordance with established guidelines or the American Psychiatric Association's Diagnostic and Statistical Manual for psychiatric patients. The American Psychiatric Association's Diagnostic and Statistical Manual

Coding shall be used in psychiatric institutions. Other methods of coding shall be used as applicable. Records shall be coded within one (1) month of discharge;

14. In-service shall be provided to the hospital's Medical Record Department employees at least on a quarterly basis and documented;

15. A master patient index shall be maintained by the hospital's Medical Record Department. Index information shall include at least the full name, address, birth date and the medical record number of the patient. The index may be maintained on cards or computerized and should contain the dates of all patient visits;

16. A unit record system shall be maintained. A unit record means all inpatient and outpatient visits for each patient being filed together in one unit;

17. A written policy and procedure manual covering all functions of the Medical Record Department shall be maintained by the hospital. This manual shall be reviewed and updated on an annual basis. A cover sheet shall be included with the manual, documenting the dates of review and revision;

18. A qualified individual shall be employed to direct the Medical Record Department. If an Accredited Record Technician (ART) or a Registered Record Administrator (RRA) is not employed as director on a full-time basis by the facility, a consultant must make periodic visits to evaluate the functions of the Medical Record Department;

19. A Medical Record Committee or its equivalent shall be established by the hospital to supervise the medical records to ensure that information is recorded in a proper manner and that sufficient data are present to evaluate the care of the patient and recommend corrective action when needed. The Committee shall be responsible for developing policies for all department functions including, but not limited to, confidentiality, filing and

completion of records. The Committee shall be responsible for ensuring that the policies for the department are enforced as well as ensuring that any medical staff rules and regulations regarding record completion are followed. The Committee membership shall consist of at least two (2) representatives from the medical staff, the Director of the Medical Record Department and a representative from Administration and Nursing Services;

20. All patient records shall be kept in two-hour fire rated enclosures and protected against undue destruction from dust, vermin, water and other matter. A smoke detector should be installed in areas where records are filed or permanently stored;

21. Written consent of the patient or legal guardian shall be presented as authority for the release of medical information;

22. Original medical records shall not be removed from the hospital except upon receipt of a subpoena duces tecum by a court of appropriate jurisdiction;

23. Medical records shall be considered confidential. Only authorized personnel shall have access to the medical records. All medical records shall be secured at all times. If authorized personnel are not present, the Medical Record Department shall be locked. Records shall be available to authorized personnel from the State Department of Health;

24. Specific policies regarding confidentiality of records for those patients that are admitted to an alcohol or drug abuse unit shall be developed; and

25. Hospital medical records shall be retained as follows:

- a. all records must be retained in either original form or microfilm or other acceptable methods for ten (10) years after the most recent admission,
- b. after ten (10) years, a medical record may be destroyed, provided the facility retains the following for twenty-five (25) years:

- (1) basic information including dates of admission and discharge,
 - (2) name of physician(s),
 - (3) record of diagnoses and/or operations,
 - (4) operative reports,
 - (5) tissue (pathology) reports, and
 - (6) discharge summaries for all admissions, and
- c. complete medical records of minors shall be retained for a period of seven (7) years after the age of majority.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-723 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Identification data of medical records shall include at least the following:

1. Patient's full name, and maiden name, if applicable;
2. Patient's address, telephone number and occupation;
3. Patient's date of birth;
4. Patient's age;
5. Patient's sex;
6. Patient's race;
7. Patient's religion;
8. Patient's marital status;
9. Dates and times of admission and discharge;
10. Full name of physician, and, if necessary, the physician's address and telephone number;
11. Name and address of the patient's nearest relative or person or agency responsible for the patient, and the occupation of the responsible party;
12. Name, address and telephone number of person(s) to notify in case of emergency;
13. Medical record number; and

14. General consent for medical treatment and care signed by the patient or legal guardian.

B. Clinical reports shall contain the following:

1. History and physical examination must be in the patient's medical record within forty-eight (48) hours of the patient's admission to the facility. The history and physical examination must be documented by the attending physician and must contain the following:

- a. family medical history and review of systems, and if noncontributory, the record should reflect such,
- b. past medical history,
- c. chief complaint(s), including a brief statement of the nature and duration of the symptoms that caused the patient to seek medical attention as stated in the patient's own words,
- d. present illness with dates or approximate dates of onset,
- e. physical examination, and
- f. provisional or admitting diagnosis(es);

2. If a patient is readmitted within thirty (30) days with the same condition, an interval note may be used by the physician. The interval note should include any changes that have taken place in the patient's history and physical examination since the previous stay and the present reason for the patient's admission;

3. A short stay medical record is acceptable in cases of a minor nature which require less than forty-eight (48) hours' hospitalization, except deaths and obstetrical cases. The short form should include, but not be limited to, identification data, pertinent physical findings, description of the patient's condition, summary of treatment given and any other information necessary to justify the diagnosis(es) and treatment;

4. Progress notes shall be recorded, dated and signed by the physician. The condition of the patient shall determine the frequency of the notes. Dictated progress notes are acceptable, if they are dictated by the attending physician, transcribed by the transcriptionist, and placed in the patient's medical record within twenty-four (24) hours to forty-eight (48) hours of dictation;

5. Orders shall be recorded, dated and signed by the attending physician. Verbal orders are acceptable, if they are recorded by the appropriate personnel, including a registered pharmacist or a licensed nurse, and cosigned by the physician within twenty-four (24) hours. Other professionals such as physical therapists may take verbal orders for patient treatments when nursing personnel are not available to coordinate services;

6. A discharge summary shall recapitulate the significant findings and events of the patient's hospitalization and his condition on discharge. This shall be documented by the attending physician within thirty (30) days of the patient's discharge. The final diagnosis shall be stated in the discharge summary. If the patient expires, the date, time and cause of the patient's death shall be stated in the discharge summary and death note. A physician must pronounce the patient dead and document the above;

7. Autopsy findings shall be documented in complete protocol within sixty (60) days and the provisional anatomical diagnosis shall be recorded within seventy-two (72) hours. A signed authorization for autopsy shall be obtained from the next of kin and documented in the medical record before an autopsy is performed;

8. Original signed diagnostic reports shall be filed in the patient's medical record. Physicians' orders must accompany all treatment procedures;

9. Reports of ancillary services including, but not limited to, dietary, physical therapy, respiratory therapy and social services,

shall be included in the patient's medical record, if ordered by the physician;

10. Reports of medical consultation, if ordered by the attending physician, shall be included in the patient's medical record within time frames established by the medical staff of the facility. The normal and customary time for consultant reports is forty-eight (48) hours;

11. An individualized nursing care plan shall be developed for each patient and made a part of the permanent medical record; and

12. If a medication administration record is maintained by the hospital, it shall include the date, time, dosage and manner of administration of all medications. The initials of the nurse administering the medication shall also be recorded. If a medication administration record is not utilized by the facility, documentation shall be reflected in the nurses' notes.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-724 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The requirements of this section shall be in addition to the general record content requirements of Section 2 of this act.

B. With respect to surgery records:

1. A specific consent for surgery shall be documented prior to the surgery or procedure to be performed, except in cases of emergency, and shall include the date, time and signatures of the patient, physician and witness. Abbreviations are not acceptable;

2. A history and physical examination on admission containing pertinent medical history and physical findings shall be documented by the attending physician on the patient's medical record prior to surgery. In cases of emergency surgery, an abbreviated physical examination and a brief description of why the surgery is needed shall be written by the physician;

3. a. A complete anesthesia report, including pre-evaluation and post follow-up, shall be documented by the anesthesiologist and certified registered nurse anesthetist, if any. The pre- and post-anesthesia evaluations should be dated and timed,
- b. The pre-operative anesthesia evaluation shall be completed prior to the patient's surgery,
- c. A report of anesthesia must be cosigned by a physician if completed by a certified registered nurse anesthetist, and
- d. A post-anesthesia evaluation must be documented in the medical record within at least three (3) to forty-eight (48) hours of the patient's surgery;

4. A post-anesthesia care unit record or recovery room record shall be maintained, if applicable;

5. An individualized operative report shall be written or dictated by the physician immediately following surgery and shall be signed within seventy-two (72) hours. The report shall describe, in detail, techniques, findings, pre- and post-operative diagnosis, and tissues removed;

6. A signed pathological report of either macroscopic and/or microscopic examinations on all tissue surgically removed shall be included. A specific list of tissues which shall be exempt from pathological examination shall be developed by the medical staff and included in the medical staff rules and regulations;

7. Outpatient surgery records are required to contain the information specified in paragraphs 3 through 6 of this subsection with the exception of a complete history and physical examination when a local anesthesia is administered. A brief history and physical evaluation pertinent to the surgical procedure that the patient is to have shall suffice; and

8. A discharge note is not required if discharge criteria has been developed and approved by the medical staff and documented by the nursing staff on the individual patient records.

C. With respect to obstetrical records:

1. A pertinent prenatal record which shall be updated upon admission, or history and physical examination signed by the physician shall be available upon the patient's admission and shall be maintained in the patient's medical record;

2. A labor and delivery record shall be maintained for every obstetrical patient;

3. Documentation of the patient's recovery from delivery should be maintained; and

4. Nurses' postpartum records or graphics and nurses' notes shall be maintained.

D. With respect to newborn records:

1. A newborn history and physical examination shall be completed by the physician within twenty-four (24) hours of birth.

The following additional data shall be required:

a. history of the newborn delivery, including the newborn's sex, date of birth, type of delivery and anesthesia given the mother during labor and delivery, and

b. physical examination, including weight, date, time of birth and condition of the infant after birth;

2. A consent for circumcision, if applicable, shall be secured;

3. A procedure note for circumcision describing technique, blood loss, complications and anesthesia, if used, shall be documented by the physician prior to the newborn's discharge;

4. A discharge note or summary shall be documented by the physician describing the condition of the newborn at discharge, and follow-up instructions given to the mother; and

5. The hospital shall document its compliance as prescribed with mandatory testing of newborn infants by law.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-725 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Medical records for outpatient services, emergency room services and observation services shall comply with this section.

B. An outpatient record shall be completed for each outpatient and shall include the following:

1. History and physical examination of the patient, unless diagnostic services and/or outpatient therapy services are provided;

2. Orders and reports of diagnostic services and outpatient therapy services;

3. Patient's diagnosis and summary of treatment received as recorded by the attending physician;

4. Documentation of any medications administered;

5. Progress notes for subsequent clinic visits recorded by the applicable practitioner; and

6. Outpatient surgery record requirements provided in subsection B of Section 3 of this act.

C. 1. An emergency room record shall be completed for each patient who presents for treatment at the emergency room and shall contain the following:

a. patient identification,

b. date and the following times:

(1) admission,

(2) when the physician was contacted by telephone,

(3) physician's arrival, and

(4) discharge,

c. history of when the injury or onset of symptoms occurred,

d. vital signs,

- e. nurses' assessment and physical findings,
- f. diagnosis, as stated by the physician,
- g. record of treatment, including documentation of verbal orders and of drug quantities administered with the initials of the person(s) administering the drugs, and, if administered, the type and amount of local anesthetic,
- h. diagnostic reports with specific orders noted,
- i. instructions to patients for follow-up care,
- j. disposition of the case, including how the patient left, the condition of the patient on discharge and if the patient was accompanied,
- k. signature of the patient or his representative, and
- l. physician's signature and date.

2. Emergency room records must be completed immediately, or if the physician treats the patient by telephone orders, they must be completed within twenty-four (24) hours.

3. When a patient is admitted as an inpatient on an emergency room visit, the medical record of the emergency room visit shall be integrated with the patient's overall medical record.

D. A record of every patient admitted to an observation bed or unit shall be maintained and shall include:

1. Identification data;
2. Nursing admission assessment by a registered nurse;
3. Nursing observations;
4. Physician's assessment of the patient;
5. Physician's order for admission and discharge from the unit and any treatment received; and
6. Record of any treatment received, including diagnostic tests and any medication administered.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-726 of Title 63, unless there is created a duplication in numbering, reads as follows:

The basic medical record requirements for psychiatric patients shall be the same as for other patient records, with the following exceptions:

1. The identification data which shall include the patient's legal status on the face sheet;
2. A proper consent or authority for admission;
3. A provisional diagnosis which shall specify both the intercurrent disease and the psychiatric diagnosis;
4. Statements and reasons for admission given by the family and by others, as well as the patient, preferably verbatim, with the informant identified;
5. A psychiatric evaluation shall be completed by the attending psychiatrist which includes the following:
 - a. the patient's chief complaints and/or reaction to hospitalization, recorded in the patient's own words, if possible,
 - b. history of the present illness, including onset, and reasons for the current admission,
 - c. past history of any psychiatric problems and treatment, including a record of the patient's activities including social, education, vocational, interpersonal and family relationships,
 - d. mental status which includes at least attitude and general behavior, affect, stream of mental activity, presence or absence of delusions and hallucinations, estimate of intellectual functions, judgment and an assessment of orientation and memory,

- e. strengths such as knowledge, interests, skills, aptitudes, experience, education and employment status,
- f. past non-psychiatric medical history and treatment, and
- g. diagnostic impressions and recommendations;

6. A physical examination shall be documented by a physician and shall include a neurological examination;

7. Social service records, including any report of interviews with patients, family members and others, shall be included for each admission;

8. Reports of consultation, psychological evaluations, reports of electroencephalograms, dental records and reports of special studies shall be included in the records when applicable;

9. An individual comprehensive treatment plan shall be developed for each patient and included in the medical record. The planning of an individual comprehensive treatment plan should involve all staff who have contact with the patient to share information and come to an agreement on goals and priorities and shall include, as a minimum:

- a. problems and needs relevant to admission and discharge as identified in the various assessments, expressed behavioral and descriptive terms,
- b. strengths or assets, including skills and interests,
- c. problems, both physical and mental, that require therapeutic intervention by the facility staff,
- d. goals and objectives describing the desired action or behavior to be achieved which should be relevant, observable and measurable,
- e. treatment modalities should be individualized in relation to the patient's needs,

- f. evidence of the patient's involvement in the formulation of the plan,
- g. the master treatment plans should be cross-referenced with other treatment plans such as nursing and activity therapy, and
- h. multidisciplinary treatment plans should include realistic discharge and aftercare plans;

10. The treatment received by the patient shall be documented in such a manner and with such frequency as to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included;

11. Progress notes shall be recorded by the physician, nurse, social worker and others involved in active treatment modalities at least weekly for the first two (2) months and at least once a month thereafter. These notes shall contain recommendations for revisions in the treatment plan, when indicated, as well as previous assessment of the patient's progress;

12. The discharge summary shall include a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up of aftercare, as well as a brief summary of the patient's condition on discharge; and

13. The psychiatric diagnosis contained in the final diagnosis and included in the discharge summary must be written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III).

SECTION 6. This act shall become effective September 1, 1993.

44-1-5642

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