

## **290-9-7-.18 Medical Records.**

(1) **Management of Patients' Medical Records.** The hospital shall have an efficient and organized medical records service that establishes the policies and procedures for the maintenance of the medical records for all patients and that is administratively responsible for the management of those records.

(a) The medical records service shall maintain a list of accepted abbreviations, symbols, and medical terminology to be utilized by persons making entries into patients' medical records.

(b) The medical records service shall utilize systems to verify the author(s) of entries in the patients' medical records. Delegation of use of computer codes, signature stamps, or other authentication systems, to persons other than the author of the entry, is prohibited.

(c) The hospital shall utilize systems defined by hospital policies and procedures to ensure that patients' medical records are kept confidential. Medical records shall be accessible only to hospital and medical staff involved in treating the patient and to other individuals as permitted by federal and state laws. The Department, in exercising its licensing authority, shall have the right to review and copy any patients' medical records.

(d) At any time during or after their course of treatment, patients shall be provided with copies of their medical records upon their written requests or the written requests of their authorized representatives in accordance with state law. Copies shall be provided within a reasonable time period not to exceed thirty (30) days after the request, unless the patient agrees to a lengthier delivery time. Copies of records shall be provided to patients for a reasonable fee in accordance with applicable laws.

(e) Copies of the patient's medical records shall be released to persons other than the patient or the patient's legally authorized representative either at the written request of the patient or as otherwise allowed by law. If the individual designated to receive a copy of the record is a health care provider, the copy of the record shall be released by the hospital in a timely manner so as not to interfere with the continuation of the patient's treatment.

(f) Patients' medical records shall be coded and indexed in a manner that allows for timely retrieval by diagnosis or procedure when necessary.

(g) The hospital shall utilize an effective process to ensure that patients' medical records are completed within thirty (30) days after the patients are discharged from the hospital. Records of other parts of patients' records that are not within the control of the hospital or its medical staff shall be added to the patients' records as soon as they become available to the hospital.

(h) The hospital shall retain all patients' medical records at least until the fifth anniversary of the patients' discharges. If the patient is a minor, the records must be retained for at least five (5) years past the age of majority. Records may be preserved in the hospital's format of choice, including but not limited to paper or electronic format, so long as the records are readable and capable of being reproduced in paper format upon request.

(i) Medical records shall be secured in such a manner as to provide protection from damage or unauthorized access.

(2) **Entries in the Medical Record.** All entries in the patient's medical records shall be

accurate and legible and shall contain sufficient information to support the diagnosis and to describe the treatment provided and the patient's progress and response to medications and treatments. Inpatient records shall also contain sufficient information to justify admission and continued hospitalization.

(a) The date of the entry and the signature of the person making the entry, shall accompany all entries in the patient's medical record. Late entries shall be labeled as late entries.

(b) The hospital, through its medical staff policies, shall appropriately limit the use of verbal/telephone orders. Verbal/telephone orders shall be used only in situations where immediate written or electronic communication is not feasible and the patient's condition is determined to warrant immediate action for the benefit of the patient. Verbal/telephone orders shall be received by an appropriately license or otherwise qualified individual as determined by the medical staff in accordance with state law.

(c) The individual receiving the verbal/telephone order shall immediately enter the order into the medical record, sign and date the order, with the time noted, and, where applicable, enter the dose to be administered.

(d) The individual receiving the order shall immediately repeat the order and the prescribing physician or other authorized practitioner shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's medical record, that the order was "repeated and verified."

(e) The verbal/telephone order shall be authenticated by the physician or other authorized practitioner giving the order, or by a physician or other authorized practitioner taking responsibility for the order, in accordance with hospital and medical staff policies.

1. Where the procedures outlined in subparagraph (2)(d) of this rule are followed, the hospital shall require authentication of all verbal/telephone orders no later than thirty (30) days after the patient's discharge.

2. As an alternative to meeting the requirements set forth in subparagraph (2)(d) of this rule, the hospital shall require that verbal/ telephone orders be authenticated within forty-eight (48) hours, except where the patient is discharged within forty-eight (48) hours of the time the verbal/telephone order was given, in which case authentication shall occur within thirty (30) days after the patient's discharge.

(f) The hospital's quality improvement plan shall include monitoring of the appropriate use of verbal/telephone orders in accordance with these rules and hospital policy and taking appropriate corrective action as necessary.

**(3) Minimum Requirements for Patients' Medical Records.** Upon completion, medical records for inpatients and outpatients shall contain, at minimum, the documents as specified below. Records for patients at the hospital for other specialized services, such as emergency services or surgical services, shall contain such additional documentation as required for those services.

**(a) Inpatient Records.** Medical records for inpatients shall contain at least the following:

1. A unique identifying number and a patient identification form, which includes the following when available: name, address, date of birth, sex, and person to be notified in an emergency;
2. The date and time of the patient's admission;

3. The admitting diagnosis and clinical symptoms;
4. The name of the attending physician;
5. Any patient allergies;
6. Documentation regarding advanced directives;
7. The report from the history and physical examination;
8. The report of the nursing assessment performed after admission;
9. Laboratory, radiological, electrocardiogram, and other diagnostic assessment data or reports as indicated;
10. Reports from any consultations;
11. The patient's plan of care;
12. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders;
13. Progress notes from staff members involved in the patient's care, which describe the patient's response to medications, treatment, procedures, anesthesia, and surgeries;
14. Data, or summary data where appropriate, from routine or special monitoring;
15. Medication, anesthesia, surgical, and treatment records;
16. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law;
17. Date and time of discharge;
18. Description of condition, final diagnosis, and disposition on discharge or transfer;
19. Discharge summary with a summary of the hospitalization and results of treatment; and
20. If applicable, the report of autopsy results.

(b) **Outpatient Records.** Medical reports for outpatients shall contain at least the following:

1. A unique identifying number and a patient identification form, which includes the following if available: name, address, date of birth, sex, and person to be notified in an emergency;
2. Diagnosis of the patient's condition;
3. The name of the physician ordering treatment or procedures;
4. Patient allergies;
5. Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders as applicable;
6. Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law;
7. Reports from any diagnostic testing; and
8. Sufficient information to justify any treatment or procedure provided, report of outcomes of treatment or procedures, and, as appropriate, progress notes and the disposition of the patient after treatment.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Medical Records" adopted. F. Nov. 22, 2002; eff. Dec. 12, 2002.