

SUBCHAPTER 15. MEDICAL RECORDS

8:43G-15.1 Medical records structural organization

- (a) There shall be a medical record department with the primary responsibility of maintaining medical records for all inpatients treated at the hospital.
- (b) There shall be a system for identifying medical records to facilitate their retrieval by patient identifier.
- (c) If the hospital ceases to operate, at least 14 days before cessation of operation the State Department of Health shall be notified in writing about how and where medical records will be stored.
- (d) The hospital shall maintain a written organizational chart for the medical record department that delineates lines of authority and responsibility in the department.
- (e) There shall be a system of access to the medical records of all patients, including outpatients.

8:43G-15.2 Medical records policies and procedures

- (a) The medical record department shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. They shall include at least:
 - 1. Procedures for record completion, including chart analysis;
 - 2. Conditions, procedures, and fees for releasing medical information; and
 - 3. Procedures for the protection of medical record information against the loss, tampering, alteration, destruction, or unauthorized use.
- (b) All entries in the patient's medical record shall be written legibly in ink, dated, and signed by the recording person or, if a computerized medical records system is used, authenticated.
 - 1. If computer generated orders with a physician's electronic signature are used, the hospital shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.
 - 2. If a facsimile communications system (Fax) is used, entries into the medical record shall be in accordance with the following procedures:
 - i. The physician shall sign the original order, history and/or examination at an off-site location;
 - ii. The original shall be Faxed to the hospital for inclusion into the medical record;
 - iii. The physician shall submit the original for inclusion into the medical record within 72 hours; and

- iv. The faxed copy shall be replaced by the original. Facsimile reports produced by a plain-paper facsimile process can be used as an original document and do not need to be replaced by an original.
- (c) Medical records, including outpatient records, shall be organized in a uniform format within each clinical service.
- (d) The inpatient's complete medical record shall include at least:
1. Written informed consents, if indicated and documentation of the existence, or nonexistence, of an advance directive and the hospital's inquiry of the patient concerning this;
 2. A complete history and physical examination, in accordance with medical staff policies and procedures;
 3. Clinical/progress notes;
 4. For surgical patients, a preanesthesia note made by the anesthesiologist before administration of anesthesia;
 5. For surgical patients, an anesthesia record by the anesthesiologist or certified registered nurse anesthetist;
 6. For surgical patients, a postanesthesia note made early in the postoperative period and after release from the recovery room by a member of the hospital's professional anesthesia team in accordance with policies and procedures developed in compliance with N.J.A.C. 8:43G-35.1(a);
 7. For surgical patients, an operative report;
 8. A postanesthesia care unit record, if applicable;
 9. Consultation reports, where applicable;
 10. Physician orders for treatment and medication;
 11. Medication record reflecting the drug given, date, time, dosage, route of administration, and signature and status of the person administering the drug. Initials may be used after the person's full signature appears at least once on each page of the medication record. Allergies, including allergy to latex, shall be listed on the medication record;
 12. A record of self-administered medications, if the patient self-administers, in accordance with the policies and procedures of the hospital's pharmacy and therapeutic committee, or its equivalent;
 13. Reports of laboratory, radiological, and diagnostic services;
 14. A discharge summary, which includes the reason for admission, findings, treatment, condition on discharge, medication on discharge, final diagnosis, and, in the case of death, the events leading to death and the cause of death. For cases where the patient is discharged

alive within 48 hours of admission and is not transferred to another facility, for normal newborns, and for uncomplicated deliveries, a discharge note may be substituted for the discharge summary. The discharge note includes at least the patient's condition on discharge, medications on discharge, and discharge instructions; and

15. A report of autopsy, if performed by the hospital, with provisional anatomic diagnoses recorded in the medical record within three days. The complete protocol is included in the medical record within the time specified in hospital policies and procedures.

- (e) Any adverse incident, including patient injuries, shall be documented in the patient's medical record.
- (f) If the patient is transferred to another health care facility (including a home health agency) on a nonemergency basis, the hospital shall maintain a transfer record reflecting the patient's immediate needs and send a copy of this record to the receiving facility at the time of transfer. The transfer record shall contain at least the following information:
 - 1. Diagnoses, including history of any serious physical conditions unrelated to the proposed treatment which might require special attention to keep the patient safe;
 - 2. Physician orders in effect at the time of discharge and the last time each medication was administered;
 - 3. The patient's nursing needs;
 - 4. Hazardous behavioral problems;
 - 5. Drug and other allergies; and
 - 6. A copy of the patient's advance directive, where available.
- (g) Medical records shall be completed within 30 days of discharge.
- (h) Medical records shall be retained and preserved in accordance with N.J.S.A. 26:8-5 et seq.
- (i) Original medical records of components of medical records shall not leave hospital premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.
- (j) Any consent form for medical treatment that the patient signs shall be printed in an understandable format and the text written in clear, legible, nontechnical language. In the case where someone other than the patient signs the forms, the reason for the patient's not signing it shall be indicated on the face of the form, along with the relationship of the signer to the patient.
- (k) The patient's death shall be documented in the patient's medical record upon death.
- (l) Recording errors in the medical record shall be corrected by drawing a single line through the incorrect entry. The date of correction and legible signature or initials of the person correcting the error shall be included.

(m) All medical records, including outpatient medical records, shall be organized in a uniform format within each clinical service.

8:43G-15.3 Medical record patient services

(a) Health care practitioners who provide clinical services to the patient shall enter clinical/progress notes in the patient's medical record, when the services are rendered.

(b) Notes that provide a full and accurate description of the care provided to the patient shall be made in the medical record at the time clinical services are provided. Notes that provide a description and an evaluation of the patient's response to treatment shall be made in the medical record.

(c) The medical record shall either accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be retrievable by authorized personnel on a computerized system with a restricted access and entry system.

(d) If a patient or the patient's legally authorized representative requests, in writing, a copy of his or her medical record, a legible, written copy of the record shall be furnished at a fee based on actual costs. One copy of the medical record from an individual admission shall be provided to the patient or the patient's legally authorized representative within 30 days of request, in accordance with the following:

1. The fee for copying records shall not exceed \$1.00 per page or \$100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than \$0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of \$200.00 for the entire record;
2. In addition to per page costs, the following charges are permitted:
 - i. A search fee of no more than \$10.00 per patient per request. (Although the patient may have had more than one admission, and thus more than one record is provided, only one search fee shall be permitted for that request. The search fee is permitted even though no medical record is found as a result of the search.); and
 - ii. A postage charge of actual costs for mailing. No charges shall be assessed other than those permitted in (d)1 and 2 above;
3. The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and
4. The hospital shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her representative, however, has a right to receive a full or certified copy of the medical record.
5. For purposes of this subsection, "legally authorized representative" means the following:

- i. Spouse;
 - ii. Immediate next of kin;
 - iii. Legal guardian;
 - iv. Patient's attorney;
 - v. Patient's third party insurer; and
 - vi. Worker's compensation carriers, where access is permitted by contract or law, but limited only to that portion of the medical record which is relevant to the specific work-related incident at issue in the worker's compensation claim.
- (e) The fee for copying medical records shall be based on actual costs, which in no case shall exceed \$1.00 per page and \$10.00 per search, in the case of the following:
1. Where the patient has authorized release of his or her medical record to a person or entity other than those identified in (d) above, including but not limited to physicians or other practitioners who provided care to the patient, or attorneys representing such providers; or
 2. The patient subsequently requests additional copies of a medical record which has been furnished in accordance with (d) above.
- (f) Access to the medical record shall be limited only to the extent necessary to protect the patient. A verbal explanation for any denial of access shall be given to the patient or legal guardian by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.
- (g) The patient shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

8:43G-15.4 Medical records staff qualifications

There shall be a full-time medical record director who is an accredited record technician or a registered record administrator under a certification program approved by the American Medical Record Association.

8:43G-15.5 Staff education

Requirements for the medical record staff education and training program shall be as provided in N.J.A.C. 8:43G-5.9.

8:43G-15.6 (Reserved)