

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 667. HOSPITAL STANDARDS**

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 15. Nursing Service
310:667-15-6 [AMENDED]
Subchapter 19. Medical records department
310:667-19-2 [AMENDED]
Subchapter 21. Drug distribution
310:667-21-8 [AMENDED]
Subchapter 39. Critical access hospital
310:667-39-9 [AMENDED]
Subchapter 40. Emergency hospital
310:667-40-9 [AMENDED]
310:667-40-11 [AMENDED]

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Oklahoma State Board of Health, 63 O.S. Sections 1-104 and 1-705

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"n/a"

ANALYSIS:

This proposal removes the forty-eight (48) hour time limit for authentication of certain verbal or telephone orders given by physicians and practitioners. The current rule requires signatures by physicians or practitioners within forty-eight (48) hours after giving verbal orders for medications, treatments and tests. After the change,

verbal and telephone orders will be authenticated pursuant to each hospital's medical staff bylaws. The proposal will enable hospitals to implement recent changes in federal rules governing Medicare certification of hospitals at Title 42 of the Code of Federal Regulations, Section 482.24(c) with the purpose of reducing a regulatory and financial burden on hospitals.

The new federal regulation authorizes authentication of verbal orders by either the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under 42 CFR § 482.12(c) and authorized to write orders by hospital policy in accordance with State law. The new federal rule strikes the forty-eight (48) hour timeframe requirement for authentication of orders and instead defers to hospital policy and State law for establishment of any timeframe. The new federal rules provide that if there is no State law establishing such a timeframe, then a hospital would be allowed to establish their own time frame for authentication of orders, including verbal orders.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 25, 2013:

SUBCHAPTER 15. NURSING SERVICE

310:667-15-6. Evaluation and review of nursing care

(a) There shall be a continuous review and evaluation of the nursing care provided for patients. There shall be written nursing care procedures and nursing care plans for patients.

(b) Nursing care policies and procedures shall be written and be consistent with current standards of practice and be reviewed and revised as necessary.

(c) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(d) Nursing care plans shall include assessment, planning, intervention, and evaluation. Nursing care plans shall be established for each inpatient and be revised as necessary.

(e) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

(f) Only the following shall be permitted to administer medications, and in all instances, in accordance with state and federal law:

(1) A licensed physician or licensed independent practitioner;

(2) A registered nurse;

(3) A licensed practical nurse; or

(4) Other practitioners, if designated by the medical staff and authorized by law.

(5) Facilities participating in a program for training nursing

students may permit nursing students to administer medications to patients provided the facility has on file an agreement between the nursing school and the facility, outlining protocols for participation, scope of involvement, education levels of students, level of supervision, and a current roster of nursing students in the program. Specific details relating to the operation of the program shall be included in the facility's policies and procedures manual.

(g) All medical orders shall be signed by the prescribing physician or practitioner. Telephone ~~and~~ or verbal orders for medications, treatments and tests shall be given only to the practitioner authorized by administration to receive these orders and be signed by the prescribing physician or practitioner ~~as soon as possible within forty-eight (48) hours~~. Other orders may be accepted by staff as designated by medical staff policy, consistent with state and federal laws. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(h) ~~Verbal~~ Telephone or verbal orders may be authenticated as described at OAC 310:667-19-2(c)(4).

(i) Blood product transfusions and intravenous medications shall be administered as required by written hospital policy in accordance with state and federal law. Hospital staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(j) An effective hospital procedure shall be established for reporting transfusion reactions and adverse drug reactions.

SUBCHAPTER 19. MEDICAL RECORDS DEPARTMENT

310:667-19-2. Reports and records

(a) Reports shall be made by each hospital to the appropriate agency, including but not limited to the following:

- (1) Communicable disease.
- (2) Births and deaths.
- (3) Periodic reports to the Department on forms supplied for this purpose.
- (4) Newborn hearing screening report.

(A) All hospital nurseries shall complete a newborn hearing screening report form on all live newborns discharged from their facility. For facilities with a two-year average annual birth census of 15 or greater, physiologic hearing screening results as well as "at risk" indicators must be recorded on the report form; for facilities with a two-year average annual birth census of fewer than 15, "at risk" indicators must be recorded and if physiologic hearing screening is conducted, those results also must be recorded on the report form. It shall be the responsibility of the hospital administrator to assure that

the Newborn Hearing Screening Report Form is correctly completed and subsequently submitted to the Department. The hospital administrator may designate one individual, who shall then be responsible for review of all newborn discharge summaries to insure that a report form has been completed for each infant and that the report form is a permanent part of that infant's record. A copy of the hearing screening report form must be given to the infant's caregiver at discharge.

(B) If an infant is transferred from one hospital to another, the second hospital shall be responsible for providing physiologic hearing screening, "risk indicator" screening, and for completion of the report form.

(C) It shall be the responsibility of the hospital administrator to insure that all completed report forms are mailed to the Department within seven (7) days of an infant's birth.

(D) It shall be the responsibility of the attending physician or licensed independent practitioner to inform parents if their infant passed or was referred on the physiologic hearing screening and/or if the infant is to be considered "at risk" for hearing impairment. Prior to discharge, the attending physician or licensed independent practitioner shall review the completed report form and shall inform the parents of their infant's status. Infants who do not pass the physiologic screening shall be referred for a diagnostic audiological evaluation as soon as possible.

(E) It shall be the responsibility of the coordinator of the Newborn Hearing Screening Program at the Department to arrange for hospital in-service training for all hospital personnel involved in the process of completion of report forms. A manual of procedures shall be available in regard to processing of screening forms. The literature for distribution to parents shall be available from the Department.

(5) Newborn metabolic disorder screening.

(A) **Testing of newborns.** All newborns in Oklahoma shall be tested for phenylketonuria, hypothyroidism, galactosemia and sickle cell diseases by a Certified Newborn Metabolic Disorder Screening Laboratory as defined in Chapter 550 of this Title; a parent or guardian may refuse metabolic disorder screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices. A parent or guardian who refuses metabolic disorder screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices shall also indicate in writing this refusal in the newborn's medical record with a copy sent to the Newborn Metabolic Disorder Screening Program, Maternal and Child Health Service, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299.

(B) **Specimen collection for hospital births.** For all live hospital births, the physician or licensed independent practitioner shall order the collection of a newborn metabolic disorder screening specimen on all newborns prior to transfusion, at three to five days of age or immediately prior to discharge, whichever comes first. Specimens shall be collected on the Newborn Metabolic Disorder Form Kit using capillary or venous blood. Cord blood is unacceptable. The hospital is responsible for collecting specimens on all infants.

(i) If the initial specimen for any infant is collected prior to 24 hours of age, the hospital and the physician or licensed independent practitioner are responsible for notifying the infant's parents that a repeat specimen is necessary at three to five days of age. The infant's physician or licensed independent practitioner is responsible for insuring that the repeat specimen is collected.

(ii) The hospital is responsible for submitting a satisfactory specimen and for documenting all requested information on the form kit including the parent/guardian's name, address, phone or contact phone number and the planned health care provider who will be providing well care for the infant after discharge, or if the infant is to be hospitalized for an extended period of time, the name of the infant's physician or licensed independent practitioner.

(iii) The hospital is responsible for documenting specimen collection and results in the infant's hospital record.

(iv) Infants transferred from one hospital to another during the newborn period shall have specimen collection documented in the infant's hospital record. It is the responsibility of the physician or licensed independent practitioner and the receiving hospital to insure a specimen is collected.

(v) It is the responsibility of the hospital and physician or licensed independent practitioner to insure that all infants are screened prior to discharge. If an infant is discharged prior to specimen collection, the Newborn Metabolic Disorder Screening Program Coordinator shall be notified by contacting Maternal and Child Health Service, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299, (405) 271-6617, FAX (405) 271-4892, 1-800-766-2223, ext. 6617. The physician or licensed independent practitioner is responsible for insuring the specimen is collected at three to five days of age.

(C) **Screening for premature/sick infants.** For all premature/sick infants, the physician or licensed independent practitioner shall order the collection of a

newborn metabolic disorder screening specimen prior to red blood cell transfusion, at three to seven days of age, or immediately prior to discharge, whichever comes first. It is recommended that a repeat newborn metabolic disorder screening specimen be collected at 14 days of age. Specimens shall be collected on the Newborn Metabolic Disorder Form Kit using capillary or venous blood. The hospital is responsible for collecting specimens on all premature/sick infants.

(i) Premature/sick infants screened prior to 24 hours of age must be re-screened between 7-14 days of age.

(ii) Premature/sick infants who could not be screened prior to a red blood cell transfusion should be re-screened by the 7th day of life and a repeat specimen collected when plasma and/or red cells will again reflect the infant's own metabolic processes or phenotype. The accepted time period to determine hemoglobin type is 90 to 120 days after transfusion.

(iii) The recommended follow-up study for an abnormal thyroid screen in a premature infant is a serum free T4 (measured by direct dialysis or an equivalent method) at 7-14 days of age.

(D) **Hospital recording.** The hospital shall implement a procedure to assure that a newborn screening specimen has been collected on every newborn and mailed to the Newborn Metabolic Disorder Screening Laboratory within 24 - 48 hours of collection.

(i) The hospital shall immediately notify the infant's physician or licensed independent practitioner, and parents or guardians if an infant is discharged without a sample having been collected. This notification shall be documented in the infant's hospital record.

(ii) If no test results are received within fifteen (15) days after the date of collection, the hospital shall contact the Newborn Metabolic Disorder Screening Laboratory to verify that a specimen had been received. If no specimen has been received, the hospital shall notify the physician or licensed independent practitioner.

(iii) Any hospital or any other laboratory which collects, handles or forwards newborn metabolic disorder screening samples shall keep a log containing name and date of birth of the infant, name of the attending physician or licensed independent practitioner, name of the health care provider who will be providing well care for the infant after discharge, medical record number, serial number of the form kit used, date the specimen was drawn, date the specimen was forwarded, date the test results were received and the test results.

(iv) The hospital is responsible for assuring that

employees who collect, handle or perform newborn metabolic screening tests are informed of their responsibilities with respect to screening procedures.

(E) **Parent and health care provider education.** The hospital will be responsible or designate a responsible party to distribute the Newborn Metabolic Disorder Screening Program's written educational materials on newborn metabolic disorder screening provided by the Department to at least one of each newborn's parent or legal guardian.

(F) **Training.** Hospitals shall provide ongoing training programs for their employees involved with newborn screening procedures. These training programs shall include methods of collecting a Satisfactory Newborn Metabolic Disorder Screening Specimen.

(6) Birth defects. Each hospital shall maintain a list of patients up to six (6) years of age who have been diagnosed with birth defects, and all women discharged with a diagnosis of stillbirth or miscarriage. On request, each hospital shall make the medical records of these individuals available to the State Department of Health.

(7) Abortions. Attending physicians shall complete and submit to the Department a report form for each abortion performed or induced as required by 63 O.S. 1999, Section 1-738.

(b) **Record of patient admission.**

(1) All persons admitted to any institution covered by these standards shall be under the care of a doctor of medicine (M.D.) or osteopathy (D.O.) duly licensed to practice medicine and surgery in the State of Oklahoma or a licensed independent practitioner, whose name shall be shown on the admitting record.

(2) The hospital admitting record also shall show the following for each patient.

(A) Full name of patient with age, sex, address, marital status, birth date, home phone number, date of admission, and admitting diagnosis.

(B) Next of kin, with address, phone number, and relationship.

(C) Date and time of admission, the admission and final diagnoses, and the name of physician or licensed independent practitioner.

(D) Any advanced directive for health care as defined in the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act.

(3) Special clinical reports shall be kept, including the following:

(A) Obstetrical patients throughout labor, delivery, and post-partum.

(B) Newborn, giving the infant's weight, length, and other notes relative to physical examination.

(C) Surgical and operative procedures, including pathological reports.

(D) Record of anesthesia administration.

(c) **Orders for medications, treatments, and tests.**

(1) All medication orders shall be written in ink and signed by the ordering physician or practitioner authorized by law to order the medication, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. The order shall be preserved on the patient's chart.

(2) All orders shall be written in ink and signed by the ordering physician or practitioner. Orders received by resident physicians shall be co-signed if required by medical staff bylaws. The order shall be preserved on the patient's chart.

(3) All orders taken from the physician or practitioner, for entry by persons other than the physician or practitioner, shall be countersigned ~~as soon as possible within forty-eight (48) hours.~~

(4) ~~Verbal~~ Telephone or verbal orders may be authenticated by an authorized physician or practitioner other than the ordering physician or practitioner when this practice is defined and approved in the medical staff bylaws. If allowed, medical staff bylaws must identify the physicians or practitioners who may authenticate another physician's or practitioner's telephone or verbal order, e.g. physician partners or attending physicians or practitioners, and define the circumstances under which this practice is allowed. The bylaws must also specify that when a covering or attending physician or practitioner authenticates the ordering physician's or practitioner's telephone or verbal order, such an authentication indicates that the covering or attending physician or practitioner assumes responsibility for his or her colleague's order and verifies the order is complete, accurate, appropriate, and final. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

SUBCHAPTER 21. DRUG DISTRIBUTION

310:667-21-8. Drug handling

(a) Drugs shall be given to hospital patients only upon written order of a physician or practitioner legally authorized to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. No change in an order shall be made without the approval of the prescriber. ~~Verbal~~ Telephone or verbal orders are discouraged but, when necessary, shall be written by an authorized employee and signed by the person legally authorized to write a prescription ~~as soon as possible within 48 hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read

the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(b) Single use units of controlled substances shall be used in the hospital except in the pharmacy where multiple dose vials may be used for IV admixtures.

(c) All Schedule drugs in the hospital, except those in the pharmacy, shall be verified by actual count at the change of shift by two (2) licensed nurses and documented. Schedule drugs outside the pharmacy which are contained in, and controlled by, an automated dispensing device may be verified by actual count at the time of each access and documented. Adequate day-to-day accountability-of-use records shall be maintained and shall include the date and time of each check of a schedule drug substance supply, the balance on hand, the names of patients receiving drugs, the physician's or prescribing practitioner's name, quantity of medication used and wasted, and the signatures of the two persons making the check. Wastage of schedule drugs shall be witnessed by at least two (2) persons, one (1) of which shall be a licensed health professional. Witnesses shall document wastage by signature.

(d) The medical staff shall establish a written policy that all toxic or dangerous drugs not specifically prescribed as to time or number of doses shall be automatically stopped after a reasonable time limit set by the staff. Examples of drugs ordinarily thought of as toxic or dangerous drugs include: controlled substances, sedatives, anticoagulants, antibiotics, oxytocics, and steroids.

(e) The administrator, or his or her authorized representative, shall inventory pharmacy controlled substances and alcohol at least annually.

(f) Drugs past the date of expiration shall be removed from stock and shall not be available for patient use.

SUBCHAPTER 39. CRITICAL ACCESS HOSPITAL

310:667-39-9. Nursing service

(a) **General.** Each CAH shall have an organized nursing service which provides twenty-four (24) hour nursing services for patients. The nursing service shall be supervised by a registered nurse.

(b) **Organization.** The nursing service shall be well-organized with written policies delineating administrative and patient care responsibilities. The director of nursing shall be a registered nurse who shall be responsible for the operation of the service, including determining the staff necessary to provide nursing care for all areas of the CAH. Nursing care shall be provided as specified by written procedures approved by the director of nursing and the governing body. All nursing procedures shall be consistent with state and federal law and current standards of practice. Procedures shall be reviewed and revised as necessary.

(c) **Staffing.** The nursing service shall have adequate numbers of licensed nurses and other nursing personnel available to provide

nursing care to all patients as needed based on patient census and acuity. At least one (1) registered nurse shall be on duty on-site to furnish or supervise all nursing services whenever patient care is provided. If the CAH has no inpatients, the registered nurse may be available on an on-call basis provided he or she is available to return to the CAH in a period of time not to exceed twenty (20) minutes.

(d) **Qualifications.**

(1) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned. The CAH shall verify current licensure of licensed nurses and maintain documentation of verification.

(2) The selection and promotion of nursing service personnel shall be based on their qualifications and capabilities. The director of nursing shall have input regarding the employment, promotion, evaluation and termination of all nursing service personnel.

(3) The qualifications required for each category of nursing staff shall be in written policy and job descriptions, and shall be available in the CAH for reference. The functions of all nursing service personnel shall be clearly defined by written policy.

(e) **Delivery of care.**

(1) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(2) Each inpatient shall have a nursing care plan that includes assessment, planning, intervention, and evaluation. Nursing care plans shall be revised as necessary.

(3) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs, ~~and biologicals, treatments and tests~~ shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, ~~or biologicals, treatments and tests~~ are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing practitioner ~~as soon as possible within forty-eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(5) Blood products and intravenous medications shall be administered as required by CAH written policy in accordance with state and federal law. CAH staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(6) There shall be an effective procedure for reporting transfusion and adverse drug reactions to the attending physician or licensed independent practitioner and the prescribing physician or practitioner. Errors in drug administration and adverse reactions shall be compiled and reported through the quality assurance committee to the medical and professional staff.

(7) All nursing service personnel shall be trained and currently certified to perform cardio-pulmonary resuscitation (CPR) and shall be knowledgeable of all CAH emergency protocols.

(f) **Patient restraint.** If patients are physically restrained, the CAH shall comply with all requirements specified in OAC 310:667-15-8. If patients are chemically restrained, the CAH shall comply with all requirements specified in OAC 310:667-15-9.

SUBCHAPTER 40. EMERGENCY HOSPITAL

310:667-40-9. Nursing service

(a) **General.** Each EH shall have an organized nursing service which provides twenty-four (24) hour nursing services for patients. The nursing service shall be supervised by a registered nurse.

(b) **Organization.** The nursing service shall be well-organized with written policies delineating administrative and patient care responsibilities. The director of nursing shall be a registered nurse who shall be responsible for the operation of the service, including determining the staff necessary to provide nursing care for the EH. Nursing care shall be provided as specified by written procedures approved by the director of nursing and the governing body. All nursing procedures shall be consistent with state and federal law and current standards of practice. Procedures shall be reviewed and revised as necessary.

(c) **Staffing.** The nursing service shall have adequate numbers of licensed nurses and other nursing personnel available to provide nursing care to all patients as needed based on patient census and acuity. At least one (1) registered nurse shall be on duty on-site to furnish or supervise all nursing services whenever patient care is provided. If the EH has no inpatients, the registered nurse may be available on an on-call basis provided he or she is available to return to the EH in a period of time not to exceed twenty (20) minutes.

(d) **Qualifications.**

(1) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned. The EH shall verify current licensure of licensed nurses and maintain documentation of verification.

(2) The selection and promotion of nursing service personnel

shall be based on their qualifications and capabilities. The director of nursing shall have input regarding the employment, promotion, evaluation and termination of all nursing service personnel.

(3) The qualifications required for each category of nursing staff shall be in written policy and job descriptions, and shall be available in the EH for reference. The functions of all nursing service personnel shall be clearly defined by written policy.

(e) **Delivery of care.**

(1) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(2) Each inpatient shall have a nursing care plan that includes assessment, planning, intervention, and evaluation. Nursing care plans shall be revised as necessary.

(3) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs and biologicals shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, ~~or biologicals,~~ treatments, and tests are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing physician or practitioner ~~as soon as possible within forty-eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(5) Blood products and intravenous medications shall be administered as required by EH written policy in accordance with state and federal law. EH staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(6) There shall be an effective procedure for reporting transfusion and adverse drug reactions to the attending physician or licensed independent practitioner and the prescribing physician or practitioner. Errors in drug administration and adverse reactions shall be compiled and reported through the quality assurance committee to the medical and professional staff.

- (7) All nursing service personnel shall be trained and currently certified to perform cardio-pulmonary resuscitation (CPR) and shall be knowledgeable of all EH emergency protocols.
- (f) **Patient restraint.** If patients are physically restrained, the EH shall comply with all requirements specified in OAC 310:667-15-8. If patients are chemically restrained, the EH shall comply with all requirements specified in OAC 310:667-15-9.

310:667-40-11. Medical record services

(a) **General.** The EH shall have medical record services that ensure a medical record is maintained for every patient evaluated or treated in the facility. Medical record services shall be appropriate to the scope and complexity of the services performed and shall ensure prompt completion, filing, and retrieval of records. In general, services such as transcription, computer indexing and coding, and electronic storage may be performed off-site as a contracted service as long as the medical record remains under the control of the EH. The EH shall ensure that medical records maintained by a contracted service remain confidential and can be immediately accessed by EH staff.

(b) **Reports to agencies and the Department.** The EH shall comply with all requirements specified in OAC 310:667-19-2(a) regarding the reports made to agencies and the Department.

(c) **Content.** The medical record shall contain information to justify patient admission and treatment, support the diagnosis, and describe the patient's progress and response to treatment and services received. All entries shall be legible and complete, and shall be authenticated and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing or evaluating the service furnished.

(1) The author of each entry shall be identified and shall authenticate their entry. Authentication may include written signatures or computerized or electronic entries. If computerized or electronic authentications are used, the EH shall comply with all requirements specified at OAC 310:667-19-10(e). Telephone ~~and~~ or verbal orders shall be authenticated by the physician or practitioner giving the order ~~as soon as possible within forty-eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician. Reports of history and physical examinations and discharge summaries shall be authenticated by the authorized physician or practitioner who performed the examination or produced the summary or meet the requirements at OAC 310:667-19-10(e) if authenticated by another physician or practitioner. Signature stamps may be used to authenticate entries in the medical record provided the requirements at OAC 310:667-19-10(d) are met.

(2) All inpatient records shall document the following as

appropriate:

(A) Patient identifying information including individuals to be contacted in case of an emergency.

(B) Evidence of a physical examination, including a health history, performed not more than thirty (30) days prior to admission or within forty-eight (48) hours after admission. The history and physical examination shall be completed, signed and placed in the record within 48 hours of admission.

(C) Admitting diagnosis.

(D) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

(E) Documentation of complications, hospital acquired infections, and unfavorable reactions to any drug or biological.

(F) Properly executed informed consent forms for procedures and treatments performed. The medical and professional staff shall establish which procedures or treatments require informed consent consistent with Federal and State law.

(G) All physicians' and practitioners' orders, nursing notes, reports of treatment, medication records, diagnostic reports, vital signs and other information necessary to monitor the patient's condition.

(H) Discharge summary with outcome of hospitalization, disposition of case, medications at the time of discharge, and provisions for follow-up care.

(I) Reports. All reports and records shall be completed and filed within a period consistent with good medical practice and not longer than thirty (30) days following discharge.

(J) Final diagnosis.

(d) **Maintenance of records.** The EH shall maintain a medical record for each emergency, stabilization, or observational patient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The EH shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(1) Medical records shall be retained at least five (5) years after the date the patient was last seen or at least of three (3) years after the date of the patient's death. Records of minors shall be retained three (3) years past the age of majority. Medical records may be maintained in their original form or may be preserved by other means as specified by OAC 310:667-19-14(b).

(2) The EH shall have, or provide, a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

(3) Medical records shall be confidentially maintained. Information from, or copies of, records shall be released only to

authorized individuals in accordance with state law, and the EH shall ensure that unauthorized individuals cannot gain access to, or alter medical records. Original medical records shall be released only in accordance with federal or state laws or by court order.

(4) Facsimile copies shall be acceptable as any portion of the medical record. If the facsimile is transmitted on thermal paper, that paper shall be photocopied to preserve its integrity in the record. Facsimile copies shall be considered the same as original copies.

(5) In the event of closure of the EH, the EH shall inform the Department of the disposition of the patient medical records. Disposition shall be in a manner to protect the integrity of the information contained in the medical record. These records shall be retained and disposed of as specified by OAC 310:667-19-14(b)(4).