§11-94-22 Medical record system.

(a) There shall be available sufficient, appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, checking, indexing, filing, and prompt retrieval of records and record data.

(b) If the employee who supervises medical records is not a registered records administrator, or accredited record technician, there shall be regularly scheduled visits by a consultant so qualified who shall provide reports to the administrator.

(c) The following information shall be obtained and entered in the patient's record at the time of admission to the facility:

(1) Identifying information such as: name, date, and time of admission, date and place of birth, citizenship status, marital status, Social Security number or an admission number which can be used to identify the patient without use of name when the latter is desirable.

(2) Name and address of next of kin or legal guardian.

(3) Sex, height, weight, race, and identifying marks.

(4) Reason for admission or referral.

(5) Language spoken and understood.

(6) Information relevant to religious affiliation.

(7) Admission diagnosis, summary of prior medical care, recent physical examination, tuberculosis status, and physician's orders.

(d) Records during stay shall also include:
(1) Appropriate authorizations and consents for medical procedures.

(2) Records of all periods of restraints with justification and authorization for each.

(3) Copies of initial and periodic examinations, evaluations, as well as progress notes at appropriate intervals.

(4) Regular review or an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies and treatments and indicating which

professional services or individual is responsible for providing the care or service.

(5) Entries describing treatments, medications, tests, and all ancillary services rendered.

(e) When a patient is transferred to another facility or discharged, there shall be:

(1) Written evidence of the reason.

(2) Except in an emergency, documentation to indicate that the patient understood the reason for transfer, or that the guardian and family were notified.

(3) A complete summary including current status and care, final diagnosis, and prognosis.

(f) There shall be a master alphabetical index of all patients admitted to the facility.

(g) All entries in the patient's record shall be:

(1) Legible, typed or written in ink.

(2) Dated.

(3) Authenticated by signature and title of the individual making the entry.

(4) All entries shall be written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical director.

(h) All information contained in a patient's record, including any information contained in an automated data bank, shall be considered confidential.

(i) The record shall be the property of the facility, whose responsibility shall be to secure the information against loss, destruction, defacement, tampering, or use by unauthorized persons.

(j) There shall be written policies governing access to, duplication of, and dissemination of information from the record.

(k) Written consent of the patient, if competent, or the guardian if patient is not competent, shall be required for the release of information to persons not otherwise authorized to receive it. Consent forms shall include:

(1) Use for which requested information is to be used.

(2) Sections or elements of information to be released and specific period of time during which the information is to be released.

(3) Consent of patient, or legal guardian, for release of any medical record information.

(l) Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with this chapter.

[Eff. May 3, 1985] (Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321-11).