

SUBCHAPTER 35. MANDATORY MEDICAL RECORDS

8:39-35.1 Mandatory organization for medical records

At least 14 days before a facility plans to cease operations, it shall notify the New Jersey State Department of Health and Senior Services in writing of the location and method of retrieval of medical records.

8:39-35.2 Mandatory policies and procedures for medical records

(a) Each active medical record shall be kept at the nurses' station for the resident's unit.

(b) The facility shall maintain for staff use a current list of standard professional abbreviations commonly used in the facility's medical records.

(c) Medical records shall be organized with a uniform format across all records.

(d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available:

1. Legible identifying data, such as resident's name, date of birth, sex, address, and next of kin, and person to notify in an emergency;

2. The name, address, and telephone number of the resident's physician, an alternate physician or advanced practice nurse, and dentist;

3. Complete transfer information from the sending facility, including results of diagnostic, laboratory, and other medical and surgical procedures, and a copy of the resident's advance directive, if available, or notice that the resident has informed the sending facility of the existence of an advance directive;

4. A history and results of a physical examination, including weight, performed by the physician or advanced practice nurse on admission, in accordance with N.J.A.C. 8:39-11.2(c) and results of the most recent examination by the physician, or advanced practice nurse, or New Jersey licensed physician assistant;

5. An assessment and plan of care made by each discipline involved in the resident's care;

6. Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms, treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided;

7. All physician's or advanced practice nurse's orders for the last three months;

8. Telephone orders, each of which shall be countersigned by a physician or advanced practice nurse within seven days, except for orders for non-prescription drugs or treatments, which shall be signed at the physician's or advanced practice nurse's next visit to the resident;

9. Records of all medications and other treatments that have been provided during the last three months;

10. Consultation reports for the last six months;

11. Records of all laboratory, radiologic, and other diagnostic tests for the last six months;
12. Records of all admissions, discharges, and transfers to and from the facility that occurred in the last three months;
13. Signed consent and release forms;
14. Documentation of the existence, or nonexistence, of an advance directive and the facility's inquiry of the resident concerning this;
15. A discharge plan for those residents identified by the facility as likely candidates for discharge into the community or a less intensive care setting; and
16. A discharge note written on the day of discharge for residents discharged to the community, a less intensive care setting, another nursing home or hospital, which includes at least the diagnosis, prognosis, and psychosocial and physical condition of the resident.

(e) The medical record shall be completed within 30 days of discharge.

(f) If part of a care plan is not implemented, the record shall explain why.

(g) All entries in the resident'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 an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.

2. If computer-generated orders with an electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of computer-generated signatures.

3. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:

i. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall sign the original order, history and/or examination at an off-site location;

ii. The original shall be FAXed to the long-term care facility for inclusion into the medical record;

iii. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall submit the original for inclusion into the medical record within 72 hours; and

iv. The FAXed copy shall be replaced by the original. If the facsimile reports are produced by a plain-paper facsimile process that produces a permanent copy, the plain-paper report may be included as a part of the medical record, as an alternate to replacement of the copy by the original report.

(h) If a resident or the resident's legally authorized representative requests, orally or in writing, a copy of his or her medical record, a legible photocopy of the record shall be furnished at a fee based on actual costs, which shall not exceed prevailing community rates for photocopying. ("Legally authorized representative" means spouse, immediate next of kin, legal guardian, resident's attorney, or third party insurer where permitted by law.) A copy of the medical record from an individual admission shall be provided to the resident or the resident's legally authorized representative within two working days of request.

1. The facility shall establish a policy assuring access to copies of medical records for residents who do not have the ability to pay; and

2. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The resident or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.

(i) Access to the medical record shall be limited only to the extent necessary to protect the resident. A verbal explanation for any denial of access shall be given to the resident or legal guardian by the physician or advanced practice nurse and there shall be documentation of this in the medical record. In the event that direct access to a copy by the resident is medically contraindicated (as documented by a physician or advanced practice nurse in the resident's medical record), the medical record shall be made available to a legally authorized representative of the resident or the resident's physician or advanced practice nurse.

(j) The resident shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

(k) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the resident, or until the resident reaches the age of 23 years, whichever is the longer period of time. A summary sheet of each medical record shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years.

SUBCHAPTER 36. ADVISORY MEDICAL RECORDS

8:39-36.1 Advisory policies and procedures for medical records

(a) The name by which the resident wishes to be called is entered on the cover or first page of the medical record.

(b) There is a comprehensive discharge summary with statistical and narrative information from each service completed for each resident.

(c) The full medical records for all discharged or deceased residents are completed within 15 days.

(d) Telephone orders are countersigned by a physician or advanced practice nurse within 48 hours except for orders for non-prescription drugs or treatments, which are countersigned within seven days.

8:39-36.2 Advisory staff education and training for medical records

The facility requires that staff use only standard professional abbreviations in medical records and maintains a current list of such abbreviations.

8:39-36.3 Advisory staff qualifications for medical records

(a) The facility utilizes the services of a medical record practitioner or consultant who is:

1. Certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611); or

2. A graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611).