



## Ohio Administrative Code

### Rule 5122-14-13 Medical records, documentation and confidentiality.

Effective: February 17, 2017

---

(A) Each inpatient psychiatric service provider shall maintain a complete medical record for each individual patient.

(B) Necessary components of the medical record shall include to the extent possible, but not be limited to, the following:

(1) Patient demographic information, including indication of legal status as a voluntary or involuntary patient;

(2) All legal documents, including, as appropriate, an application for voluntary admission signed and dated by the patient, written requests for release pursuant to section 5122.03 of the Revised Code, and all legal documents pertaining to civil commitment and guardianship.

For patients with a guardian, the inpatient psychiatric service provider shall make effort to obtain all needed consent forms signed and dated by the guardian. If the guardian is unable to provide written consent, the provider may obtain and document verbal consent of the guardian as long as two individuals document, in writing, that each witnessed the guardian provide the verbal consent.

(3) The reason for admission including presenting problem(s), precipitating factors, and initial diagnosis;

(4) Previous hospitalizations;

(5) Reports of all patient assessments and examinations;

(6) An individualized treatment plan which shall include criteria for discharge and which shall meet requirements of section 5122.27 of the Revised Code;



(7) All medical orders;

(8) Documentation of the patient's progress, and other significant patient events which could impact on treatment;

(9) Appropriate, complete, signed and dated consents for treatment, and for release of confidential information;

(10) A discharge summary completed within thirty days after discharge and signed by the attending or treating physician; and

(11) A post discharge plan.

(C) All entries in the medical record shall be dated, signed, and legible.

(D) Each inpatient psychiatric service provider shall be responsible for conducting a complete assessment of each patient including a consideration of the patient's strengths and patient's needs, and types of services to meet those needs in the least restrictive environment consistent with treatment needs.

(1) The assessments shall include as appropriate to patient need: physical, laboratory, emotional, behavioral, social, recreational, cognitive, functional living skills, educational, legal, vocational, nutritional, cultural, religious, income support, housing needs, and other community support and discharge planning needs.

(2) Each inpatient psychiatric service provider shall define in writing the scope of assessments to be performed by each clinical discipline not otherwise specified in this chapter, consistent with the discipline's scope of practice, state licensure laws, applicable regulations, certification, or registration.

(E) Written assessments of each patient shall be provided and dated by the respective interdisciplinary team members as soon as possible after admission and prior to the development of the treatment plan which is required within twenty-four hours of admission unless otherwise



specified in this rule.

(1) For new admissions if assessments are available from prior evaluations and/or admissions within the past six months, each assessment shall be reviewed, revised as necessary, dated, and signed by a member of the respective discipline as soon as possible after admission and prior to the development of the treatment plan.

(2) The following required patient assessments shall be completed within twenty-four hours of a patient's admission:

(a) A physician shall be responsible for a medical history and physical examination. If the patient's condition does not permit completion of the examination each part of the examination shall be completed as soon as the patient's condition permits it. If a physician was responsible for the completion of a medical history and physical examination within thirty days of the current course of treatment and the patient's condition remains consistent with the results of that examination, a signed copy of this history and examination may suffice. The medical history and physical examination may be conducted by a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted by applicable law or regulation.

(i) The history and physical examination shall include a basic neurological examination that includes an examination of the cranial nerves, sensory and motor functions, coordination, and deep tendon reflexes.

(ii) If the patient is a child, adolescent, or person with mental retardation/developmental disabilities, the history and physical examination shall include evaluations of motor development and functioning, sensorimotor functioning, speech, hearing and language functioning, visual functioning, immunization status, and oral health and oral hygiene;

(b) A psychiatrist, or a physician with specific clinical privileges to conduct such an examination shall be responsible for a psychiatric examination including a mental status examination. The psychiatric examination may be conducted by a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized in accordance with his or her scope of practice and as permitted



by applicable law or regulation;

(c) A registered nurse shall be responsible for completing an assessment of each patient's nursing care needs. As part of the nursing assessment, the R.N. shall conduct a screening of each patient's nutritional status unless otherwise assessed by a registered dietitian;

(d) An assessment for functional and rehabilitation needs which may include activities of daily living; community living skills; social, leisure and vocational skills; self care and self control abilities; physical/sensori-motor capabilities, speech, language, oral, and pharyngeal sensor-motor competencies and auditory and vestibular competencies;

(e) An emotional and behavioral assessment which includes at least a history of emotional, behavioral, substance-abuse problems or treatment and physical or sexual abuse history;

(f) A psycho-social assessment which shall include the following information about the patient, as appropriate:

(i) Environment and home;

(ii) Leisure and recreation;

(iii) Work history;

(iv) Spirituality;

(v) Childhood history;

(vi) Military service history;

(vii) Financial status;

(viii) Usual social, peer-group, and environmental setting;



(ix) Sexual orientation; and

(x) Family circumstances, including the constellation of the family group, the current living situation, and social, ethnic, cultural, emotional, and health factors. The psychosocial assessment includes determining the need and extent for family participation;

(g) In programs serving children and adolescents, an assessment shall be performed which includes the following:

(i) The impact of the child's/adolescent's condition on the family and the family's impact on the child/adolescent;

(ii) The child/adolescent's legal custody status, when applicable;

(iii) The child/adolescent's growth and development, including physical, emotional, cognitive, educational, nutritional, and social development;

(iv) The child/individual's play and daily activities needs; and

(v) The family's or guardian's expectations for and involvement in the child/adolescent's assessment, initial treatment, and continuing care.

(F) Each patient shall have a written individualized treatment plan that is responsive and timely to the treatment needs of the patient based on information provided by the patient and the patient's family and assessments by the clinical treatment team. The initial treatment plan and subsequent revisions shall be developed with the active participation of the patient, and through collaborative efforts of the clinical team. As appropriate and with patient consent, family members and significant others shall also participate. Such patient, family, and clinical treatment team collaboration shall be documented on the treatment plan. A patient's inability or refusal to participate in treatment planning and the patient's reasons for such shall also be documented on the treatment plan. The patient, and as appropriate parent or guardian, shall have the right to be informed of changes on the treatment plan including a change in assignment of the primary therapist or attending physician.



(1) The initial treatment plan shall be developed with the active participation of the patient and implemented within twenty-four hours of admission through collaborative efforts by the interdisciplinary clinical treatment team.

(2) The initial treatment plan and any subsequent revisions to the plan shall:

(a) Reflect the patient's clinical needs, condition, functional strengths, and limitations.

(i) The patient's perceptions of his/her needs are documented, as are the families' perceptions when appropriate and available.

(ii) Justification is documented when identified needs are not addressed;

(b) Specify goals for achieving emotional and/or physical health as well as maximum growth and adaptive capabilities.

(i) Treatment plan goals are based on assessments of the patient and, as appropriate, the family.

(ii) Treatment plan goals are linked to living, learning, and work activities.

(iii) Treatment goals identified by the patient and actions the patient agrees to or requests to take, and the patient's involvement in and expressed concerns about the treatment plan are documented;

(c) Specify intermediate steps toward those goals in measurable terms;

(d) Specify target dates or time-frames for completion of goals and steps;

(e) Specify services and interventions to be provided to achieve patient goals, and to indicate the staff person(s) and/or discipline responsible for provision of service(s);

(f) Specify frequency of services; and

(g) Specify criteria for discharge.



(3) The initial treatment plan shall be reviewed, updated and/or revised within seventy-two hours of a patient's admission. All subsequent updates to the plan shall occur at least every seven days for the first month of hospitalization, at least monthly thereafter, and as appropriate to patient needs.

(G) The discharge summary completed within thirty days after discharge shall include:

(1) Assessment of the patient's condition on admission;

(2) Assessment of the patient's condition upon discharge and reason for discharge;

(3) Description of diagnostic and treatment services received by the patient, with reference to interventions identified on the treatment plan, and the patient's response;

(4) All recommendations made to the patient;

(5) Medications prescribed upon discharge; and

(6) Initial and final diagnosis, both physical and psychiatric, according to the American psychiatric association's latest edition of the diagnostic and statistical manual of mental disorders (DSM), which shall be recorded in full without the use of either symbols or abbreviations.

(H) A discharge plan shall be developed with each patient and shall:

(1) State all appropriate recommendations and specific plans to include but not be limited to psychiatric, medical, case management, housing, vocational, financial, educational needs, other community support needs, and community resources available to meet these needs;

(2) Identify specific resources and state recommendations for continued, ongoing patient and family education regarding the nature and management of the patient's illness/disorder;

(3) Specify persons or agencies responsible for each recommended intervention or service;



- (4) Specify the time-frame for initiation of each recommended intervention or service;
  - (5) Specify a crisis management plan as described in paragraph (Q)(1)(a) of rule 5122-14-12 of the Administrative Code; and
  - (6) Be signed and dated by the patient, or as appropriate parent or guardian, and by each member(s) of the clinical treatment team responsible for reviewing the plan with the patient. A patient's inability or refusal to sign or participate in discharge planning and the patient's reasons for such shall be documented on the plan.
- (I) The patient's treatment plan and medical record shall be available to the patient and family members according to section 5122.31 of the Revised Code.
- (J) The inpatient psychiatric service provider shall have written policies and procedures regarding the release of information and confidentiality of oral or written patient information, in compliance with section 5122.31 of the Revised Code.