Ohio Administrative Code

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

Effective: April 24, 2024

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

(B) A medical record is to include all of 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 is to make an 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 problems, precipitating factors, and initial diagnosis;

(4) Previous hospitalizations;

(5) Reports of all patient assessments and examinations;

(6) An individualized treatment plan that includes criteria for discharge and meets mandates in section 5122.27 of the Revised Code;

(7) All medical orders;

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

(9) Appropriate, complete, signed, and dated consents for treatment and 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 are to be dated, signed, and legible.

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

(1) The assessments are to 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 is to 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 are to 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 mandated 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 is to 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 mandated patient assessments are to be completed within twenty-four hours of a patient's admission:

(a) A medical history and physical examination is to be completed by a physician. If the patient's condition does not permit completion of the examination, each part of the examination is to 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 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 is to 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 an intellectual or developmental disability, the history and physical examination is to 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 psychiatric examination, including mental status examination, is to be competed by a psychiatrist or a physician with specific clinical privileges to conduct such an examination. Alternatively, the psychiatric examination may be conducted by a physician 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) An assessment of each patient's nursing care needs to be completed by a registered nurse. As part of the nursing assessment, the registered nurse is to conduct a screening of each patient's nutritional status unless otherwise assessed by a registered dietitian.

(d) An assessment for functional and rehabilitation needs is to be completed. The assessment may include an evaluation of the patient's 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. The assessment is to include an evaluation of the patient's history of emotional, behavioral, substance-abuse problems or treatment, and physical or sexual abuse.

(f) A psycho-social assessment. The assessment is to 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 is to be performed that includes an evaluation of all of the following:

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

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

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

(iv) The child's or adolescent's play and daily activities needs; and

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

(F) Each patient is to 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 are to 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 are also to participate. Such patient, family, and clinical treatment team collaboration is to be documented in the treatment plan. A patient's inability or refusal to participate in treatment planning and the patient's reasons for such are to also be documented in the treatment plan. The patient, and as appropriate parent or guardian, is to have the right to be informed of changes in the treatment plan including a change in assignment of the primary therapist or attending physician.

(1) The initial treatment plan is to 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 are to do all of the following:

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

(i) The patient's perceptions of his or 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 indicate the staff persons and/or discipline responsible for provision of services;

(f) Specify frequency of services; and

(g) Specify criteria for discharge.

(3) The initial treatment plan is to be reviewed, updated, and/or revised within seventy-two hours of a patient's admission. All subsequent updates to the plan are to 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 is to include all of the following:

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

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

(3) A 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 is to be recorded in full without the use of either symbols or abbreviations.

(H) A discharge plan is to be developed with each patient and is to do all of the following:

(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 or 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 is to be documented in the plan.

(I) The patient's treatment plan and medical record are to be available to the patient and family members in accordance with section 5122.31 of the Revised Code.

(J) The inpatient psychiatric service provider is to 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.