150.013: CLINICAL AND RELATED RECORDS

(A) All facilities shall provide conveniently located and suitably equipped areas for the recording and storage of records.

(B) All records shall be permanent, either typewritten or legibly written in ink (no record shall be written in pencil). No erasures or ink eradicator shall be used or pages removed.

(C) All records shall be complete, accurate, current, available on the premises of the facility for inspection and maintained in a form and manner approved by the Department. The following records shall be maintained:

1. Daily census.
2. Employee records on all employees.
3. Patient care policies.
4. Incident, fire, epidemic, emergency and other report forms.
5. Schedules of names, telephone numbers, dates and alternates for all emergency or "on call" personnel.
6. A Patient or Resident Roster approved by the Department.
7. A Doctor's Order Book with a stiff cover and indexed, looseleaf pages. The Doctor's Order Book shall be current and accurate and shall include all medications, treatments, diets, restorative services and medical procedures ordered for patients or residents. Orders shall be dated, recorded and signed (telephone orders countersigned) by the attending physician or nurse practitioner or physician assistant. Facilities may keep Doctors' Order sheets in the patients' or residents' clinical record provided this procedure is so stated in the facility's written policies. The Doctors' Order sheets shall contain all data listed above.
8. A bound Narcotic and Sedative Book with a stiff cover and numbered pages.
9. A Pharmacy Record Book with stiff cover and numbered pages.
10. A bound Day and Night Report Book with a stiff cover and numbered pages.
11. Individual patient or resident clinical records in stiff-covered folders.
12. Record forms to record medical, nursing, social and other service data.
13. Identification and summary sheets on all patients or residents.
14. Record forms for listing patients' or residents' clothing, personal effects and valuables.
(D) All facilities shall maintain a separate, complete, accurate and current clinical record in the facility for each patient or resident from the time of admission to the time of discharge. This record shall contain all medical, nursing and other related data. All entries shall be dated and signed. This record shall be kept in an individual folder at the nurses’ or attendants’ station. The clinical record shall include:

(1) Identification and Summary Sheet including: patient’s or resident’s name, bed and room number, social security number, age, sex, race, marital status (married, separated, widowed or divorced), religion, home address, and date and time of admission; names, addresses and telephone numbers of attending physician or physician-physician assistant team or physician-nurse practitioner team and alternates, of referring agency or institution, and of any other practitioner attending the patient or resident (dentist, podiatrist); name, address and telephone number of next of kin or sponsor; admitting diagnosis, final diagnosis, and associated conditions on discharge; and placement.

(2) A Health Care Referral Form, Hospital Summary Discharge Sheets and other such information transferred from the agency or institution to the receiving facility (105 CMR 150.003(C)(1)).

(3) Admission Data recorded and signed by the admitting nurse or responsible person including: how admitted (ambulance, ambulation or other); referred by whom and accompanied by whom, date and time of admission; complete description of patient’s or resident’s condition upon admission, including vital signs on all admissions and weight (if ambulatory); and date and time attending physician or physician-physician assistant team or physician-nurse practitioner team notified of the admission.

(4) Initial Medical Evaluation and medical care plan including: medical history, physical examination, evaluation of mental and physical condition, diagnoses, orders and estimation of immediate and long-term health needs dated and signed by the attending physician (105 CMR 150.005(F)(1)) or signed by a nurse practitioner or physician assistant and countersigned by the supervising physician within ten days for Level I and Level II patients and within 30 days for Level III...patients (105 CMR 150.005(F)(4)).

(5) Physician’s or Physician-Physician Assistant Team’s or Physician-Nurse Practitioner Team’s Progress Notes including: significant changes in the patient’s or resident’s condition, physical findings and recommendations recorded at each visit, and at the time of periodic reevaluation and revision of medical care plans (105 CMR 150.005(G)).

(6) Consultation Reports including: consultations by all medical, psychiatric, dental or other professional personnel who are involved in patient or resident care and services, recorded in each patient’s or resident’s clinical record. Such records shall include date, signature and explanation of the visit, findings, treatments and recommendations.

(7) Medication and Treatment Record including: date, time, dosage and method of administration of all medications; date and time of all treatments; special diets; restorative therapy services and special procedures for each patient or resident, dated and signed by the nurse or individual who administers the medication or treatment.

(8) A Record of all fires and all incidents involving patients or residents and personnel while on duty (105 CMR 150.002(D)(6)(c)).
(9) A Nursing Care Plan for each patient or resident (105.150.007(D)(2)).

(10) Nurses Notes containing accurate reports of all factors pertaining to the patient's or resident's needs or special problems and the overall nursing care provided.

(11) Initial Plans and written evidence of periodic review and revision of dietary, social service, restorative therapy services, activity, and other patient or resident care plans.

(12) Laboratory and X-ray Reports.

(13) A list of each patient's or resident's clothing, personal effects, valuables, funds or other property (105 CMR 150.002(E)(2), 150.002(E)(3)).

(14) Discharge or Transfer Data including: a dated, signed physician's order or physician assistant's order or nurse practitioner's order for discharge; the reason for discharge and a summary of medical information, including physical and mental condition at time of discharge; a complete and accurate health care referral form; date and time of discharge; address of home, agency or institution to which discharged; accompanied by whom; and notation as to arrangements for continued care or follow-up.

(15) Utilization Review Plan, Minutes, Reports and Special Studies.

(17) Certified facilities that admit residents with MR or DD/ORC shall maintain as part of the resident's record the DMR Rolland Integrated Service Plan (RISP) and the Specialized Service Provider Plan.

(E) All clinical records of residents or patients including those receiving outpatient restorative services shall be completed within two weeks of discharge and filed and retained for at least five years. Provisions shall be made for safe keeping for at least five years of all clinical records in the event the facility discontinues operation, and the Department shall be notified as to the location of the records and the person responsible for their maintenance.

(F) All information contained in clinical records shall be treated as confidential and shall be disclosed only to authorized persons.

(G) All facilities shall employ a medical records librarian or shall designate a trained employee of the facility to be responsible for ensuring that records are properly maintained, completed and preserved.