R 325.21102 PATIENT CLINICAL RECORDS.

Rule 1102.

(1) A clinical record shall be provided for each patient in the home. The clinical record shall be current and entries shall be dated and signed.

(2) The clinical record shall include, at a minimum, all of the following:

(a) The identification and summary sheet, which shall include all of the following patient information:

(i) Name.

(ii) Social security number.

(iii) Veteran status and number.

(iv) Marital status.

(b) Name, address, and telephone number of next of kin, legal guardian, or designated representative.

(c) Name, address, and telephone number of person or agency responsible for patient's maintenance and care in the home.

(d) Date of admission.

(e) Clinical history and physical examination performed by the physician within 5 days before or on admission, including a report of chest x rays performed within 90 days of admission and a physician's treatment plan.

(f) Admission diagnosis and amendments thereto during the course of the patient's stay in the home.

(g) Consent forms as required and appropriate.

(h) Physician's orders for medications, diet, rehabilitative procedures, and other treatment or procedures to be provided to the patient.

(i) Physician's progress notes written at the time of each visit describing the patient's condition and other pertinent clinical observations.

(j) Nurse's notes and observations by other personnel providing care.

(k) Medication and treatment records.
(1) Laboratory and x-ray reports.

(m) Consultation reports.

(n) Time and date of discharge, final diagnosis and place to which patient was discharged, condition on discharge, and name of person, if any, accompanying patient.

(3) Copies of clinical history and physical examination report, discharge summary, transfer form, and other pertinent information arriving at the home with the patient upon transfer from another health facility shall be maintained in the facility.

(4) Clinical records of discharged patients shall be completed within 30 days following discharge.

(5) Clinical records shall be under the supervision of a full-time employee of the home.

(6) Clinical records are retained for a minimum of 6 years from the date of discharge or, in the case of a minor, 3 years after the individual comes of age under state law, whichever is longer.

(7) If a facility ceases to operate, the clinical records shall be transferred with the individual to another health care facility. It is the responsibility of the owner or corporate body to maintain clinical records of discharged patients for the length of retention as stated in subrule (6) of this rule.

(8) If the department believes that patient clinical records are not being properly maintained or completed, the department may order a home to secure from a registered record administrator or accredited record technician on-site consultation of up to 4 hours per quarter until the problem is corrected.

Sec. 20175. (1) A health facility or agency shall keep and maintain a record for each patient including a full and complete record of tests and examinations performed, observations made, treatments provided...

(3) Unless otherwise provided by law, the licensing and certification records required by this article are public records.

(4) Departmental officers and employees shall respect the confidentiality of patient clinical records and shall not divulge or disclose the contents of records in a manner that identifies an individual except pursuant to court order.