12 VAC 5-371-360. CLINICAL RECORDS. (REVISED 1/11/2006)

A. The nursing facility shall maintain an organized clinical record system in accordance with recognized professional practices. Written policies and procedures shall be established specifying content and completion of clinical records.

B. Clinical records shall be confidential. Only authorized personnel shall have access as specified in §8.01-413 and § 32.1-127.1:03 of the Code of Virginia.

C. Records shall be safeguarded against destruction, fire, loss or unauthorized use.

D. Overall supervisory responsibility for assuring that clinical records are maintained, completed and preserved shall be assigned to an employee of the nursing facility. The individual shall have work experience or training which is consistent with the nature and complexity of the record system and be capable of effectively carrying out the functions of the job.

E. An accurate and complete clinical record shall be maintained for each resident and shall include, but not be limited to:

1. Resident identification;

2. Designation of attending physician;

3. Admitting information, including resident medical history, physical examination and diagnosis;

4. Physician orders, including all medications, treatments, diets, restorative and special medical procedures required;

5. Progress notes written at the time of each visit;

6. Documented evidence of assessment of resident's needs, establishment of an appropriate treatment plan, and interdisciplinary plan of care;

7. Nurse's notes written in chronological order and signed by the individual making the entry;

8. All symptoms and other indications of illness or injury, including date, time, and action taken on each shift;

9. Medication and treatment record, including all medications, treatments and special procedures performed;
10. Copies of radiology, laboratory and other consultant reports; and

11. Discharge summary.

F. Verbal orders shall be immediately documented in the clinical record by the individual authorized to accept the orders, and shall be countersigned.

G. Clinical records of discharged residents shall be completed within 30 days of discharge.

H. Clinical records shall be kept for a minimum of five years after discharge or death, unless otherwise specified by state or federal law.

I. Permanent information kept on each resident shall include:

1. Name;

2. Social security number;

3. Date of birth;

4. Date of admission and discharge; and

5. Name and address of guardian, if any.

J. Clinical records shall be available to residents and legal representatives, if they wish to see them.

K. When a nursing facility closes, the owners shall make provisions for the safekeeping and confidentiality of all clinical records.