

203.PATIENT/RESIDENT RECORDS.

The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. (1-1-88)

01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person. (1-1-88)

02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: (1-1-88)

a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. (1-1-88)

b. Medical history and physical examination, including both diagnosis and rehabilitative potential, signed by the attending physician. (1-1-88)

c. Transfer or referral report, where applicable. (1-1-88)

d. Special reports dated and signed by the person making the report, i.e., laboratory, X-ray, physical therapy, social services, consultation, and other special reports. (1-1-88)

e. Physician's order record containing the physician's authorization for required medications, tests, treatments, and diet. Each entry shall be dated and signed, or countersigned, by the physician. (1-1-88)

f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. (1-1-88)

g. Nurses' entries shall include the following information: (1-1-88)

i. Date, time and mode of admission; documentation of the patient's/resident's general physical and skin condition as well as mental attitude upon admission. (1-1-88)

ii. Medication administration record. (1-1-88)

- iii. Date and times of all treatments and dressings. (1-1-88)
- iv. Any change in the patient's/resident's physical or mental status. (1-1-88)
- v. Any incident or accident occurring while the patient/resident is in the facility. (1-1-88)
- vi. Date of each physician's visit. (1-1-88)
- vii. Observations by licensed nursing personnel on labile, terminal, or acutely-ill patients/residents shall be recorded daily on each shift. (1-1-88)
- viii. Observations by qualified nursing personnel on all other patients/residents shall be summarized and recorded at least monthly. (1-1-88)
- h. Miscellaneous. Releases, consents, mortician's receipt. (1-1-88)
- i. The signature of the charge nurse for each shift indicating the assumption of responsibility for all entries made by nonprofessional nursing personnel. (1-1-88)

03. Discharged Patients'/Residents' Records. (7-1-93)

- a. Following the discharge or death of a patient/resident, the records clerk shall place the chart in chronological order and review the entire record for completeness. (1-1-88)
- b. If incomplete, the chart shall be returned to the proper person for prompt completion. No chart shall be permanently filed until all portions are complete. (1-1-88)

04. Retention. (7-1-93)

- a. There shall be adequate filing equipment and space to store closed charts and facilitate retrieval. (1-1-88)
- b. Records shall be preserved in a safe location protected from fire, theft, and water damage for a period of time not less than seven (7) years. If the patient/resident is a minor, the record shall be preserved for a period of not less than seven (7) years following his eighteenth birthday. (1-1-88)

05. Confidentiality. The facility shall safeguard medical record information against loss, destruction, and unauthorized use. (1-1-88)