

Subchapter H. Resident Clinical Records

§9857. General Provisions

A. The nursing home shall maintain clinical records on each resident in accordance with accepted professional standards and practices. Each resident's clinical record shall be complete, accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:61 (January 1998).

§9859. Maintenance of Records

A. The overall supervisory responsibility for the resident record service shall be assigned to a responsible employee of the facility.

B. All entries in the clinical record shall be either typewritten or legibly written in ink, dated, and signed.

C. If electronic signatures are used, the nursing home shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.

D. If a facsimile communications system (FAX) is used, the nursing home shall take precautions when thermal paper is used to ensure that a legible copy is retained as long as the clinical record is retained.

E. A nursing home record may be kept in any written, photographic, microfilm, or other similar method or may be kept by any magnetic, electronic, optical, or similar form of data compilation which is approved for such use by the department.

F. No magnetic, electronic, optical, or similar method shall be approved unless it provides reasonable safeguards against erasure or alteration.

G. A nursing home may, at its discretion, cause any nursing home record or part to be microfilmed, or similarly reproduced, in order to accomplish efficient storage and preservation of nursing home records.

H. Upon an oral or written request, the nursing home shall give the resident or his/her legal representative access to all records pertaining to himself/herself including current clinical records within 24 hours, excluding weekends and holidays. After receipt of his/her records for inspection, the nursing home shall provide, upon request and two working days notice, at a cost consistent with the provisions of R.S. 40:1299(A)(2)(b), photocopies of the records or any portions of them.

I. The nursing home shall ensure that all clinical records are completed within 90 days of discharge, transfer, or death. All information pertaining to a resident's stay is centralized in the clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:61 (January 1998).

§9861. Content

A. The clinical record contains sufficient information to identify the resident clearly, to justify the diagnosis and treatment, and to document the results accurately.

B. As a minimum, each clinical record shall contain:

1. sufficient information to identify the resident;
 2. physician's orders;
 3. progress notes by all practitioners and professional personnel providing services to the resident;
 4. a record of the resident's assessments;
 5. the plan of care;
 6. entries describing treatments and services provided;
- and
7. reports of all diagnostic tests and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:62 (January 1998).

§9863. Confidentiality

A. The nursing home shall safeguard clinical record information against loss, destruction, or unauthorized use. The nursing home shall ensure the confidentiality of resident records, including information in a computerized record system, except when release is required by transfer to another health care institution, law, third party payment contract, or the resident. Information from or copies of records may be released only to authorized individuals, and the nursing home must ensure that unauthorized individuals cannot gain access to or alter resident records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:62 (January 1998).

§9865. Retention

A. Clinical records shall be retained for a minimum of six years following a resident's discharge or death, unless the records are pertinent to a case in litigation, in which instance they shall be retained indefinitely or until the litigation is resolved.

B. A nursing home which is closing shall notify the department in writing at least 14 days prior to cessation of operation of their plan for the disposition of residents' clinical records for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:62 (January 1998).