

.20 Clinical Records.

A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices.

B. Contents of Record. Contents of record shall be:

(1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion;

(2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative;

(3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided;

(4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form);

(5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances);

(6) Medical and social history of patient;

(7) Report of physical examination;

(8) Diagnostic and therapeutic orders;

(9) Consultation reports;

(10) Observations and progress notes;

(11) Reports of medication administration, treatments, and clinical findings;

(12) Discharge summary including final diagnosis and prognosis;

(13) Discipline assessment; and

(14) Interdisciplinary care plan.

C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions.

D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified.

E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.

F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer.

G. Current Records—Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).

H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval.