

SECTION .2400 - MEDICAL RECORDS

10A NCAC 13D .2401 MAINTENANCE OF MEDICAL RECORDS

(a) The facility shall establish a medical records service. It shall be directed, staffed and equipped to ensure:

- (1) records are processed, indexed and filed accurately;
- (2) records are stored in such a manner as to provide protection from loss, damage or unauthorized use;
- (3) records contain sufficient information to identify the patient plus a record of all assessments; plan of care; pre-admission screening, if applicable; records of implementation of plan of care; progress notes; and record of discharge, including a discharge summary signed by the physician; and
- (4) records are readily accessible by authorized personnel.

(b) The facility shall ensure that a master patient index is maintained, listing patients alphabetically by name, dates of admission, dates of discharge and case number.

(c) The administrator shall designate an employee who works full-time to be the medical records manager. The manager shall advise, administer, supervise and perform work involved in the development, analysis, maintenance and use of medical records and reports. If that employee is not qualified by training or experience in medical record science, he or she shall receive consultation from a registered records administrator or an accredited medical record technician to ensure compliance with rules contained in this Subchapter. The facility shall provide orientation, on-the-job training and in-service programs for all medical records personnel.

*History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996.*

10A NCAC 13D .2402 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records shall ensure that medical records, whether original, computer media or microfilm, be kept on file for a minimum of five years following the discharge of an adult patient.

(b) The manager of medical records shall ensure that if the patient is a minor when discharged from the nursing facility, records shall be kept on file until his or her 19th birthday and, then, for five years.

(c) If a facility discontinues operation, the licensee shall make known to the Division of Health Service Regulation where its records are stored. Records are to be stored in a business offering retrieval services for at least 11 years after the closure date.

(d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall take precautions to ensure the confidentiality and safekeeping of the records. The original of the microfilmed medical records shall not be destroyed until the manager of medical records has had an opportunity to review the processed film for content.

(e) Nothing in this Subchapter shall be construed to prohibit the use of automation of medical records, provided that all of the provisions in this Rule are met and the medical record is readily available for use in patient care.

(f) All medical records are confidential. Only authorized personnel shall have access to the records. Signed authorization forms concerning approval or disapproval of release of medical information outside the facility shall be a part of each patient's medical record. Representatives of the Department shall be notified at the time of inspection of the name and record number of any patient who has denied medical record access to the Department.

(g) Medical records are the property of the facility, and they shall not be removed from the facility except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

*History Note: Authority G.S. 131E-104;
Eff. January 1, 1996.*