

33-07-03.2-17. Resident record services.

The governing body of the facility shall establish and implement policies and procedures to ensure the facility has a resident record service with administrative responsibility for resident records.

1. A resident record must be maintained and kept confidential for each resident admitted to the facility. The resident record shall be complete, accurately and legibly documented, and readily accessible.

a. The resident or the resident's legal representative have the right to view and authorize release of their medical information.

b. The facility shall develop policies which address access to resident records.

c. Resident records may be removed from the facility only upon subpoena, court order, or pursuant to facility policies when a copy of the original record is maintained at the facility.

2. All records of discharged residents must be preserved for a period of ten years from date of discharge. Records of deceased residents must be preserved to seven years.

a. In the case of minors, records must be retained for the period of minority and ten years from the date of live discharge. Records of deceased residents who are minors must be preserved for the period of minority and seven years.

b. It is the governing body's responsibility to determine which records have research, legal, or medical value and to preserve such records beyond the above-identified timeframes until such time the governing body determines the records no longer have a research, legal, or medical value.

3. If the facility does not employ an accredited record technician or registered record administrator, an employee of the facility must be assigned the responsibility for ensuring that records are maintained, completed, and preserved. The designated employee shall receive consultation at least annually from an accredited record technician or registered record administrator.

4. Each resident record must include:

a. The name of the resident, personal licensed health care practitioner, dentist, and designated representative or other responsible person, admitting diagnosis, final diagnosis, condition on discharge, and disposition.

b. Initial medical evaluation including medical history, physical examination, and diagnosis.

c. A report from the licensed health care practitioner who attended the resident in the hospital or other health care setting, and a transfer form used under a transfer agreement.

d. Licensed health care practitioner's orders, including all medication, treatments, diet, restorative plan, activities, and special medical procedures.

e. Licensed health care practitioner's progress notes describing significant changes in the resident's condition, written at the time of each visit.

f. Current comprehensive resident assessment and plan of care.

g. Quarterly reviews of resident assessments and nurse's notes containing observations made by nursing personnel for the past year.

h. Medication and treatment records including all medications, treatments, and special procedures performed.

i. Laboratory and x-ray reports.

j. Consultation reports.

k. Dental reports.

l. Social service notes.

m. Activity service notes.

n. Resident care referral reports.

5. All entries into the resident record must be authenticated by the individual who made the written entry, as defined by facility policy and applicable state laws and regulations, and must at a minimum include the following:

a. All entries the licensed health care practitioner personally makes in writing must be signed and dated by the licensed health care practitioner.

b. Telephone and verbal orders may be used provided they are given only to qualified licensed personnel and reduced to writing and signed or initialed by a licensed health care practitioner responsible for the care of the patient.

c. Signature stamps may be used consistent with facility policies as long as the signature stamp is used only by the licensed health care practitioner whose signature the signature stamp represents. Written assurance must be on file from the licensed health care practitioner to indicate the practitioner is the sole user of the signature stamp.

d. Electronic signatures may be used if the facility's medical staff and governing body adopt a policy permitting authentication by electronic signature. The policy must include:

(1) The staff within the facility authorized to authenticate entries in resident records using an electronic signature.

(2) The safeguards to ensure confidentiality, including:

(a) Each user must be assigned a unique identifier generated through a confidential access code.

(b) The facility shall certify in writing each identifier is kept strictly confidential. This certification must include a commitment to terminate the user's use of that particular identifier if it is found the identifier has been misused. Misused means the user has allowed another individual to use the user's personally assigned identifier, or the identifier has otherwise been inappropriately used.

(c) The user must certify in writing the user is the only individual with user access to the identifier and the only individual authorized to use the signature code.

(d) The facility shall monitor the use of the identifiers periodically and take corrective action as needed. The process by which the facility will conduct the monitoring must be described in policy.

(3) A process to verify the accuracy of the content of the authenticated entries, including:

(a) A system that requires completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps, or obvious contradictory statements appearing within those designated fields. The system must require that correction or supplementation of previously authenticated entries must be made by additional entries, separately authenticated and made subsequent in time to the original entry.

(b) An opportunity for the user to verify the accuracy of the document and to ensure the signature has been properly recorded.

(c) As part of the quality improvement activities, the facility shall periodically sample records generated by the system to verify accuracy and integrity of the system.

(4) A user may terminate authorization for use of an electronic signature upon written notice to the staff member in charge of resident records.

(5) Each report generated by the user must be separately authenticated.

(6) A list of confidential access codes must be maintained under adequate safeguards by facility administration.

History: Effective July 1, 1996.

General Authority: NDCC 23-01-03, 28-32-02

Law Implemented: NDCC 23-16-01, 28-32-02