

CHAPTER 44:04:09

MEDICAL RECORD SERVICES

Section

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44:04:09:01. Record services for hospitals and nursing facilities. All hospitals and nursing facilities must comply with §§ 44:04:09:02 to 44:04:09:05, inclusive.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:02. Medical record department. There must be an organized medical record system. A medical record must be maintained for each level of care for each patient or resident admitted to the facility.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995; 26 SDR 96, effective January 23, 2000.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:03. Medical record department staff. The medical record functions must be performed by persons trained and equipped to facilitate the accurate processing, checking, indexing, filing, and retrieval of all medical records. The individual responsible for the medical records service must have knowledge and training in the field of medical records.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:04. Written policies and confidentiality of records. There must be written policies and procedures to govern the administration and activities of the medical record service. They must include policies and procedures pertaining to the confidentiality and safeguarding of medical records, the record content, continuity of a patient's or resident's medical records during subsequent admissions, requirements for completion of the record, and the entries to be made by various authorized personnel.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:05. Record content. Each medical record must show the condition of the patient or resident from the time of admission until discharge and must include the following:

- (1) Identification data;
- (2) Consent forms, except when unobtainable;
- (3) History of the patient or resident;
- (4) A current overall plan of care;
- (5) Report of the initial and periodic physical examinations, evaluations, and all plans of care with subsequent changes;
- (6) Diagnostic and therapeutic orders;
- (7) Progress notes from all disciplines, including practitioners, physical therapy, occupational therapy, and speech pathology;
- (8) Laboratory and radiology reports;
- (9) Description of treatments, diet, and services provided and medications administered;
- (10) All indications of an illness or an injury, including the date, the time, and the action taken regarding each;
- (11) A final diagnosis; and
- (12) A discharge summary, including all discharge instructions for home care.

Source: SL 1975, ch 16, § 1; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 19 SDR 172, effective May 19, 1993; 26 SDR 96, effective January 23, 2000.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:06. Record service for assisted living centers. Each assisted living center must maintain a care record on each resident; must have written procedures for documentation, filing, and retrieval of records; and must have written policies to safeguard the residents' records against destruction, loss, and unauthorized use. The resident care records are to include the following:

- (1) Admission and discharge data including disposition of unused medications;
- (2) Report of the physician's admission physical evaluation for resident;
- (3) Physician orders;
- (4) Medication entries;
- (5) Observations by personnel, resident's physician, or other persons authorized to care for the resident; and

(6) Documentation that assures the individual needs of residents are identified and addressed.

Source: SL 1975, ch 16, § 1; 4 SDR 14, effective September 14, 1977; 6 SDR 93, effective July 1, 1980; 14 SDR 81, effective December 10, 1987; 22 SDR 70, effective November 19, 1995; 27 SDR 59, effective December 17, 2000; 30 SDR 84, effective December 4, 2003.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:07. Authentication. A health care facility must ensure entries to the medical or care record are signed or electronically authenticated. If the facility permits any portion of the medical or care record to be generated by electronic or optical means, policies and procedures must exist to prohibit the use of authentication by unauthorized users.

Source: 19 SDR 172, effective May 19, 1993; 27 SDR 59, effective December 17, 2000; 30 SDR 84, effective December 4, 2003.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:08. Retention of medical or care records. A health care facility must retain medical or care records for a minimum of ten years from the actual visit date of service or resident care. The retention of the record for ten years is not affected by additional and future visit dates. Records of minors must be retained until the minor reaches the age of majority plus an additional two years, but no less than ten years from the actual visit date of service or resident care. Initial, annual, and significant-change resident assessment records, as required in §§ 44:04:06:15 and 44:04:06:16, must be retained for ten years from the actual visit date of resident care. The retention of the record for ten years is not affected by additional and future visit dates.

Source: 19 SDR 172, effective May 19, 1993; 22 SDR 70, effective November 19, 1995; 26 SDR 96, effective January 23, 2000; 27 SDR 59, effective December 17, 2000; 28 SDR 83, effective December 16, 2001; 31 SDR 62, effective November 7, 2004.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

Cross-Reference: Storage of medical or care records, § 44:04:09:09.

44:04:09:09. Storage of medical or care records. A health care facility must provide for filing, safe storage, and easy accessibility of medical or care records. The medical or care records must be preserved as original records or in other readily retrievable and reproducible form. Medical or care records must be protected against access by unauthorized individuals. All medical or care records must be retained by the health care facility upon change of ownership.

Source: 19 SDR 172, effective May 19, 1993; 27 SDR 59, effective December 17, 2000; 30 SDR 84, effective December 4, 2003.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

Cross-Reference: Disposition of medical or care records on closure of facility or transfer of ownership, § 44:04:09:11.

44:04:09:10. Destruction of medical or care records. After the minimum retention period of ten years from the actual visit date of care outlined in § 44:04:09:08, the medical or care record may be destroyed at the discretion of the health care facility. Before the destruction of the medical or care record, the health care facility must prepare and retain a patient or resident index or abstract. The patient or resident index or abstract must include:

- (1) Name;
- (2) Medical record number;
- (3) Date of birth;
- (4) Summary of visit dates;
- (5) Attending or admitting physician; and
- (5) Diagnosis or diagnosis code.

The health care facility must destroy the medical or care record in a way that maintains confidentiality.

Source: 19 SDR 172, effective May 19, 1993; 27 SDR 59, effective December 17, 2000; 31 SDR 62, effective November 7, 2004.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

44:04:09:11. Disposition of medical or care records on closure of facility or transfer of ownership. If a health care facility ceases operation, the facility must provide for safe storage and prompt retrieval of medical or care records and the patient or resident indexes specified in § 44:04:09:10. The health care facility may arrange storage of medical or care records with another health care facility of the same licensure classification, transfer medical or care records to another health care provider at the request of the patient or resident, relinquish medical records to the patient or resident or the patient's or resident's parent or legal guardian, or arrange storage of remaining medical records with a third party vendor who undertakes such a storage activity. At least 30 days before closure, the health care facility must notify the department in writing indicating the provisions for the safe preservation of medical or care records and their location and publish in a local newspaper the location and disposition arrangements of the medical or care records.

If ownership of the health care facility is transferred, the new owner shall maintain the medical or care records as if there was not a change in ownership.

Source: 19 SDR 172, effective May 19, 1993; 27 SDR 59, effective December 17, 2000.

General Authority: SDCL 34-12-13.

Law Implemented: SDCL 34-12-13.

Cross-Reference: Storage of medical or care records, § 44:04:09:09.

44:04:09:12. Resident assessment records -- Submission to Department of Social Services -- Retention. Repealed.

Source: 17 SDR 122, effective February 24, 1991, and April 1, 1991; transferred from § 44:04:01:09, 22 SDR 70, effective November 19, 1995; repealed, 26 SDR 96, effective January 23, 2000.