§ 558.301 Client Records

(a) In accordance with accepted principles of practice, an agency must establish and maintain a client record system to ensure that the care and services provided to each client are completely and accurately documented, readily accessible, and systematically organized to facilitate the compilation and retrieval of information.
(1) An agency must establish a record for each client and must maintain the record in accordance with and contain the information described in paragraph (9) of this subsection. An agency must keep a single file or separate files for each category of service provided to the client and the client's family. Hospice services provided to a client's family must be documented in the clinical record.
(2) The agency must adopt and enforce written procedures regarding the use and removal of records, the release of information, and when applicable, the incorporation of clinical, progress, or other notes into the client record. An agency may not release any portion of a client record to anyone other than the client except as allowed by law.
(3) All information regarding the client's care and services must be centralized in the client's record and be protected against loss or damage.
(4) The agency must establish an area for original active client record storage at the agency's place of business. The original active client record must be stored at the place of business (parent agency, branch office, or ADS) from which services are provided. Original active client records must not be stored at an administrative support site or records storage facility.
(5) The agency must ensure that each client's record is treated with confidentiality, safeguarded against loss and unofficial use, and is maintained according to professional standards of practice.
(6) A clinical record must be an original, a microfilmed copy, an optical disc imaging system, or a certified copy.
(A) An original record is a signed paper record or an electronically signed computer record. A signed paper record may include a physician's stamped signature if the agency meets the following requirements:
(i) An agency must have on file at the agency a current written authorization letter from the physician whose signature the stamp represents, stating that he is the only person authorized to have the stamp and use it.
(ii) The authorization letter must be dated before a stamped record from the physician was accepted by the agency.
(iii) An agency must obtain a new authorization letter from the physician annually. A physician authorization letter is void one year from the date of the letter.
(iv) The authorization letter must be manually signed by the physician and include a copy of the stamped signature that the physician will use.
(B) Computerized records must meet all requirements of paper records, including protection from unofficial use and retention for the period specified in subsection (b) of this section.

(C) An agency must ensure that entries regarding the delivery of care or services are not altered without evidence and explanation of such alteration.
(7) Each entry to the client record must be current, accurate, signed, and dated with the date of entry by the individual making the entry. The record must include all services whether furnished directly or under arrangement. Correction fluid or tape must not be used in the record. Corrections must be made by striking through the error with a single line and must include the date the correction was made and the initials of the person making the correction.
(8) Inactive client records may be preserved on microfilm, optical disc or other electronic means and may be stored at the parent agency location, branch office, ADS, administrative support site, or records storage facility. Security must be maintained, and the record must be readily retrievable by the agency.
(9) Each client record must include the following elements as applicable to the scope of services provided by the agency:
(A) client application for services including, but not limited to, the following information:
(i) the client's full name;
(ii) sex;
(iii) date of birth;
(iv) the name, address, and telephone number of each parent or legal guardian of a minor child;
(v) the name, address, and telephone number of any other person, as identified by the individual;
(vi) the physician's name and telephone numbers, including emergency numbers; and
(vii) services requested;
(B) initial health assessment, pertinent medical history, and subsequent health assessments;
(C) care plan, plan of care, or individualized service plan, as applicable. The care plan or the plan of care must include, as applicable, medication, dietary, treatment, and activities orders. An individualized service plan for a personal assistance service client must comply with § 558.404 of this chapter (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services). A plan of care for a hospice client must comply with § 558.821 of this chapter (relating to Hospice Plan of Care;
(D) clinical and progress notes. Such notes must be written the day service is rendered and incorporated into the client record within 14 working days;
(E) current medication list;
(F) medication administration record (if medication is administered by agency staff). Notation must also be made in the medication administration record or in the clinical notes of medications not given and the reason. Any adverse reaction must be reported to a supervisor and documented in the client record;
(G) acknowledgement of hospice agency's policy regarding disposal of controlled substance prescription drugs;
(H) records of supervisory visits;
(I) complete documentation of all known services and significant events. Documentation

must show that effective interchange, reporting, and coordination of care occurs as required in §558.288 of this division (relating to Coordination of Services);
(J) for clients 60 years and older, acknowledgment of the client's receipt of a copy of the right and responsibilities listed in Texas Human Resources Code Chapter 102;
(K) acknowledgment of the client's receipt of the agency's policy relating to the reporting of abuse, neglect, or exploitation of a client;
(L) documentation that the client has been informed of how to register a complaint in accordance with §558.282(d) of this division (relating to Client Conduct and Responsibility and client Rights);
(M) client agreement to and acknowledgment of services by home health medication aides, if home health medication aides are used;
(N) discharge summary, including the reason for discharge or transfer and the agency's documented notice to the client, the client's physician (if applicable), and other individuals as required in §558.295 of this division (relating to Client Transfer or Discharge Notification Requirements);
(O) acknowledgement of receipt of the notice of advance directives;
(P) services provided to the client's family (as applicable); and
(Q) consent and authorization and election forms, as applicable.
(b) An agency must adopt and enforce a written policy relating to the retention of records in accordance with this subsection.
(1) An agency must retain original client records for a minimum of five years after the discharge of the client.
(2) The agency may not destroy client records that relate to any matter that is involved in litigation if the agency knows the litigation has not been finally resolved.
(3) There must be an arrangement for the preservation of inactive records to insure compliance with this subsection.

Notes
26 Tex. Admin. Code § 558.301
The provisions of this §558.301 adopted to be effective February 1, 2002, 26 TexReg 9159; amended to be effective June 1, 2006, 31 TexReg 1455; amended to be effective May 1, 2008, 33 TexReg 1136; Transferred from Title 40, Chapter 97 by Texas Register, Volume 44, Number 15, April 12, 2019, TexReg 1893, eff. 5/1/2019; Amended by Texas Register, Volume 46, Number 15, April 9, 2021, TexReg 2431, eff. 4/25/2021