411-086-0300 Clinical Records

(1)

Clinical Records Department. The facility shall ensure the preparation, completeness, accuracy, preservation, and filing of a clinical record for each resident in accordance with facility policy (OAR 411-085-0210). This rule does not apply to nonmedical records.

(2)

Director. The facility shall designate in writing a staff person to function as clinical records coordinator who shall ensure compliance with this rule. Services of a qualified medical record consultant (RRA or ART) shall be provided as needed.

(3)

Staffing, Equipment. There shall be personnel, space, and equipment to provide efficient, systematic processing of clinical records including but not limited to reviewing, indexing, filing, and prompt retrieval.

(4)

Filing. A system of identification and filing to ensure the rapid location of resident clinical records shall be maintained. A resident master index containing at least the full name of each resident, date of birth, clinical record number as applicable, date of admission, date of discharge, legal representative and physician of record shall be maintained.

(5)

Content of Clinical Record. A clinical record shall be maintained for each resident. Each record shall contain supporting data, written in sequence of events to justify the diagnosis and warrant the treatment and results. All entries shall be kept current, accurate, dated and signed. All clinical records shall be either typewritten or recorded legibly in ink and shall include but not be limited to the following information: (a) Admitting diagnosis and identification data including the resident's name, previous address, date and time of admission, sex, date of birth, marital status, religious preference and social security number; name, address, and telephone number of nearest relative or personal agent; place admitted from; attending physician; alternate physician (clinic or service); dentist; legal representative and RN care manager; (b) A medical history and physical exam or medical summary as to the resident's condition which is signed by a physician. If a resident is re-admitted within 30 days for the same condition, the previous history and physical or medical summary, with an interval note signed by a physician, will suffice. If an ongoing clinical record is maintained in a comprehensive care facility, it may be used if accompanied by a physical exam report completed within the previous 30 days; (c) Clinical reports, current, dated, and signed. Such reports include, but are not limited to, laboratory, x-ray, and results of tests/exams including those for communicable diseases; (d) Physician's orders, current, dated and signed; (e) Physician's progress notes dated and signed; (f) Timely, written, dated, pertinent, complete and signed clinical observations. Clinical observations shall include changes in condition, results of treatments and medications, and unusual events. Clinical observations shall include outcome of the resident care plan and shall be summarized by nursing staff at least quarterly unless the resident's condition dictates otherwise; (g) Record of medication administration including name of drug, dosage, frequency, mode of administration, date, time and

signature of the person administering medication. Documentation shall also include, when applicable, site of injection, reaction, reason for withholding any medication, and reason for administering any "prn" (as needed) medication; (h) Record of treatments administered which shall be dated, timed and signed by those performing treatments; (i) Miscellaneous items such as releases, consent forms, mortician's receipts, valuables list and medical correspondence as applicable; (j) Discharge summary prepared in accordance with OAR 411-086-0160 and signed by the attending physician. The summary shall include admitting diagnosis/reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan if appropriate, condition on discharge or cause of death; and (k) The "Directive to Physicians" ("Living Will"), the Power of Attorney for Health Care and similar legal documents regarding resident care directives, if any, shall be filed in the resident's clinical record in a manner which makes them prominent and conspicuous.

(a)

Admitting diagnosis and identification data including the resident's name, previous address, date and time of admission, sex, date of birth, marital status, religious preference and social security number; name, address, and telephone number of nearest relative or personal agent; place admitted from; attending physician; alternate physician (clinic or service); dentist; legal representative and RN care manager;

(b)

A medical history and physical exam or medical summary as to the resident's condition which is signed by a physician. If a resident is re-admitted within 30 days for the same condition, the previous history and physical or medical summary, with an interval note signed by a physician, will suffice. If an ongoing clinical record is maintained in a comprehensive care facility, it may be used if accompanied by a physical exam report

completed within the previous 30 days;

(c)

Clinical reports, current, dated, and signed. Such reports include, but are not limited to, laboratory, x-ray, and results of tests/exams including those for communicable diseases;

(d)

Physician's orders, current, dated and signed;

(e)

Physician's progress notes dated and signed;

(f)

Timely, written, dated, pertinent, complete and signed clinical observations. Clinical observations shall include changes in condition, results of treatments and medications, and unusual events. Clinical observations shall include outcome of the resident care plan and shall be summarized by nursing staff at least quarterly unless the resident's condition dictates otherwise;

(g)

Record of medication administration including name of drug, dosage, frequency, mode of administration, date, time and signature of the person administering medication. Documentation shall also include, when applicable, site of injection, reaction, reason for withholding any medication, and reason for administering any "prn" (as needed) medication;

(h)

Record of treatments administered which shall be dated, timed and signed by those performing treatments;

(i)

Miscellaneous items such as releases, consent forms, mortician's receipts, valuables list

and medical correspondence as applicable;

(j)

Discharge summary prepared in accordance with OAR 411-086-0160 and signed by the attending physician. The summary shall include admitting diagnosis/reason for admission, summary of the course of treatment in the facility, final diagnosis with a follow-up plan if appropriate, condition on discharge or cause of death; and

(k)

The "Directive to Physicians" ("Living Will"), the Power of Attorney for Health Care and similar legal documents regarding resident care directives, if any, shall be filed in the resident's clinical record in a manner which makes them prominent and conspicuous.

(6)

Record Retention. All clinical records shall be kept for a period of five years after the date of last discharge of the resident. A clinical record for each resident for whom care has been provided in the previous six months shall be immediately available for review by Division representatives upon request.

(7)

Resident Transfer. When a resident is transferred to another facility, the following information shall accompany the resident: (a) The name of the facility from which transferred; (b) The names of attending physicians prior to transfer; (c) The name of physician to assume care; (d) The date and time of discharge; (e) Most recent history and physical; (f) Current diagnosis, orders from a physician for immediate care of the resident, nursing, and other information germane to the resident's condition; (g) A copy of the discharge summary. If the discharge summary is not available at time of transfer, it shall be transmitted as soon as available, but no later than seven days after transfer; and (h) A copy of the current Directive and Power of Attorney for Health Care, if any.

(a)

The name of the facility from which transferred;

(b)

The names of attending physicians prior to transfer;

(c)

The name of physician to assume care;

(d)

The date and time of discharge;

(e)

Most recent history and physical;

(f)

Current diagnosis, orders from a physician for immediate care of the resident, nursing, and other information germane to the resident's condition;

(g)

A copy of the discharge summary. If the discharge summary is not available at time of transfer, it shall be transmitted as soon as available, but no later than seven days after transfer; and

(h)

A copy of the current Directive and Power of Attorney for Health Care, if any.

(8)

Ownership of Records. Clinical records are the property of the licensee. The clinical record, either in original or microfilm form, shall not be removed from the control of the facility except where necessary for a judicial or administrative proceeding. Authorized representatives of the Division shall be permitted to review and obtain copies of clinical records as necessary to determine compliance with OAR 411: (a) If a facility changes ownership all clinical records in original or microfilm form shall

remain in the facility and ownership shall be transferred to the new licensee; (b) In the event of dissolution of a facility, the administrator shall ensure that clinical records are transferred to another health care facility or to the resident's primary care physician, and shall notify the Division as to the location of each clinical record. The party to whom the records are transferred must have agreed to serve as custodian of the records.

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