DHS 132.45 Records

(1)

GENERAL. The administrator or administrator's designee shall provide the department with any information required to document compliance with ch. DHS 132 and ch. 50, Stats., and shall provide reasonable means for examining records and gathering the information.

(2)

PERSONNEL RECORDS. A separate record of each employee shall be maintained, be kept current, and contain sufficient information to support assignment to the employee's current position and duties.

(3)

MEDICAL RECORDS - STAFF. Duties relating to medical records shall be completed in a timely manner.

(4)

MEDICAL RECORDS - GENERAL. (c) Unit record. A unit record shall be maintained for each resident and day care client. (f) Retention and destruction. 1. An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least 5 years following a resident's discharge or death when there is no requirement in state law. All other records required by this chapter shall be retained for a period of at least 2 years. 2. A facility shall arrange

for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes. 3. If the ownership of a facility changes, the medical records and indexes shall remain with the facility. (g) Records documentation. 1. All entries in medical records shall be accurate, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. 2. A rubber stamp reproduction or electronic representation of a person's signature may be used instead of a handwritten signature, if:a. The stamp or electronic representation is used only by the person who makes the entry; and b. The facility possesses a statement signed by the person, certifying that only that person shall possess and use the stamp or electronic representation. 3. Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

(c)

Unit record. A unit record shall be maintained for each resident and day care client.

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Retention and destruction. 1. An original medical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of this resident shall be retained for a period of at least 5 years following a resident's discharge or death when there is no requirement in state law. All other records required by this chapter shall be retained for a period of at least 2 years. 2. A facility shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the facility closes. 3. If the ownership of a facility changes, the medical records and indexes shall remain with the facility.

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Symbols and abbreviations may be used in medical records if approved by a written facility policy which defines the symbols and abbreviations and which controls their use.

(5)

MEDICAL RECORDS - CONTENT. Except for persons admitted for short-term care, to whom s. DHS 132.70(7) applies, each resident's medical record shall contain: (a) Identification and summary sheet. (b) Physician's documentation. 1. An admission medical evaluation by a physician or physician extender, including: a. A summary of prior treatment; b. Current medical findings; c. Diagnoses at the time of admission to the facility; d. The resident's rehabilitation potential; e. The results of the physical examination required by s. DHS 132.52(3); and f. Level of care; 2. All physician's orders including, when applicable, orders concerning:a. Admission to the facility as required by s. DHS 132.52(2) (a); b. Medications and treatments as specified by s. DHS 132.60(5); c. Diets as required by s. DHS 132.63(4); d. Rehabilitative services as required by s. DHS 132.64(2); e. Limitations on activities; f. Restraint orders as required by s. DHS 132.60(6); and g. Discharge or transfer as required by s. DHS 132.53; 3. Physician progress

notes following each visit. 4. Annual physical examination, if required; and 5. Alternate visit schedule, and justification for such alternate visits. (c) Nursing service documentation. 1. A history and assessment of the resident's nursing needs as required by s. DHS 132.52; 2. Initial care plan as required by s. DHS 132.52(4), and the care plan required by s. DHS 132.60(8); 3. Nursing notes are required as follows: a. For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least weekly; and b. For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least every other week; 4. In addition to subds. 1., 2., and 3., nursing documentation describing:a. The general physical and mental condition of the resident, including any unusual symptoms or actions; b. All incidents or accidents including time, place, details of incident or accident, action taken, and follow-up care; c. The administration of all medications (see s. DHS 132.60(5) (d)), the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions; d. Food and fluid intake, when the monitoring of intake is necessary; e. Any unusual occurrences of appetite or refusal or reluctance to accept diets; f. Summary of restorative nursing measures which are provided; g. Summary of the use of physical and chemical restraints. h. Other non-routine nursing care given; i. The condition of a resident upon discharge; and j. The time of death, the physician called, and the person to whom the body was released. (d) Social service records. Notes regarding pertinent social data and action taken. (e) Activities records. Documentation of activities programming, a summary of attendance, and quarterly progress notes. (f) Rehabilitative services. 1. An evaluation of the rehabilitative needs of the resident; and 2. Progress notes

detailing treatment given, evaluation, and progress. (h) Dental services. Records of all dental services. (i) Diagnostic services. Records of all diagnostic tests performed during the resident's stay in the facility. (j) Plan of care. Plan of care required by s. DHS 132.60(8). (k) Authorization or consent. A photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident and any resident consent form required under this chapter, except that if the authorization or consent form exceeds one page in length an accurate summary may be substituted in the resident record and the complete authorization or consent form shall in this case be maintained as required under sub. (6) (i). The summary shall include: 1. The name and address of the guardian or other person having authority to speak or act on behalf of the resident; 2. The date on which the authorization or consent takes effect and the date on which it expires; 3. The express legal nature of the authorization or consent and any limitations on it; and 4. Any other factors reasonably necessary to clarify the scope and extent of the authorization or consent. (L) Discharge or transfer information. Documents, prepared upon a resident's discharge or transfer from the facility, summarizing, when appropriate: 1. Current medical findings and condition; 2. Final diagnoses; 3. Rehabilitation potential; 4. A summary of the course of treatment; 5. Nursing and dietary information; 6. Ambulation status; 7. Administrative and social information; and 8. Needed continued care and instructions.

(a)

Identification and summary sheet.

(b)

Physician's documentation. 1. An admission medical evaluation by a physician or physician extender, including: a. A summary of prior treatment; b. Current medical

findings; c. Diagnoses at the time of admission to the facility; d. The resident's rehabilitation potential; e. The results of the physical examination required by s. DHS 132.52(3); and f. Level of care; 2. All physician's orders including, when applicable, orders concerning:a. Admission to the facility as required by s. DHS 132.52(2) (a); b. Medications and treatments as specified by s. DHS 132.60(5); c. Diets as required by s. DHS 132.63(4); d. Rehabilitative services as required by s. DHS 132.64(2); e. Limitations on activities; f. Restraint orders as required by s. DHS 132.60(6); and g. Discharge or transfer as required by s. DHS 132.53; 3. Physician progress notes following each visit. 4. Annual physical examination, if required; and 5. Alternate visit schedule, and justification for such alternate visits.

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An admission medical evaluation by a physician or physician extender, including: a. A summary of prior treatment; b. Current medical findings; c. Diagnoses at the time of admission to the facility; d. The resident's rehabilitation potential; e. The results of the physical examination required by s. DHS 132.52(3); and f. Level of care;

a.

A summary of prior treatment;

b.

Current medical findings;

c.

Diagnoses at the time of admission to the facility;

d.

The resident's rehabilitation potential;

e.

The results of the physical examination required by s. DHS 132.52(3); and

f.

Level of care;

2.

All physician's orders including, when applicable, orders concerning:a. Admission to the facility as required by s. DHS 132.52(2) (a); b. Medications and treatments as specified by s. DHS 132.60(5); c. Diets as required by s. DHS 132.63(4); d. Rehabilitative services as required by s. DHS 132.64(2); e. Limitations on activities; f. Restraint orders as required by s. DHS 132.60(6); and g. Discharge or transfer as required by s. DHS 132.53;

a.

Admission to the facility as required by s. DHS 132.52(2) (a);

b.

Medications and treatments as specified by s. DHS 132.60(5);

c.

Diets as required by s. DHS 132.63(4);

d.

Rehabilitative services as required by s. DHS 132.64(2);

e.

Limitations on activities;

f.

Restraint orders as required by s. DHS 132.60(6); and

g.

Discharge or transfer as required by s. DHS 132.53;

3.

Physician progress notes following each visit.

4.

Annual physical examination, if required; and

5.

Alternate visit schedule, and justification for such alternate visits.

(c)

Nursing service documentation. 1. A history and assessment of the resident's nursing needs as required by s. DHS 132.52; 2. Initial care plan as required by s. DHS 132.52(4), and the care plan required by s. DHS 132.60(8); 3. Nursing notes are required as follows: a. For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least weekly; and b. For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least every other week; 4. In addition to subds. 1., 2., and 3., nursing documentation describing:a. The general physical and mental condition of the resident, including any unusual symptoms or actions; b. All incidents or accidents including time, place, details of incident or accident, action taken, and follow-up care; c. The administration of all medications (see s. DHS 132.60(5) (d)), the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions; d. Food and fluid intake, when the monitoring of intake is necessary; e. Any unusual occurrences of appetite or refusal or reluctance to accept diets; f. Summary of restorative nursing measures which are provided; g. Summary of the use of physical and chemical restraints. h. Other non-routine nursing care given; i. The condition of a resident upon discharge; and j. The time of death, the physician called, and the person to whom the body was released.

1.

A history and assessment of the resident's nursing needs as required by s. DHS 132.52;

2.

Initial care plan as required by s. DHS 132.52(4), and the care plan required by s. DHS

132.60(8);

3.

Nursing notes are required as follows: a. For residents requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least weekly; and b. For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least every other week;

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b.

For residents not requiring skilled care, a narrative nursing note shall be required as often as needed to document the resident's condition, but at least every other week;

4.

In addition to subds. 1., 2., and 3., nursing documentation describing:a. The general physical and mental condition of the resident, including any unusual symptoms or actions; b. All incidents or accidents including time, place, details of incident or accident, action taken, and follow-up care; c. The administration of all medications (see s. DHS 132.60(5) (d)), the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions; d. Food and fluid intake, when the monitoring of intake is necessary; e. Any unusual occurrences of appetite or refusal or reluctance to accept diets; f. Summary of restorative nursing measures which are provided; g. Summary of the use of physical and chemical restraints. h. Other non-routine nursing care given; i. The condition of a resident upon discharge; and j. The time of death, the physician called, and the person to whom the body was released.

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The general physical and mental condition of the resident, including any unusual symptoms or actions;

b.

All incidents or accidents including time, place, details of incident or accident, action taken, and follow-up care;

c.

The administration of all medications (see s. DHS 132.60(5) (d)), the need for PRN medications and the resident's response, refusal to take medication, omission of medications, errors in the administration of medications, and drug reactions;

d.

Food and fluid intake, when the monitoring of intake is necessary;

e.

Any unusual occurrences of appetite or refusal or reluctance to accept diets;

f.

Summary of restorative nursing measures which are provided;

g.

Summary of the use of physical and chemical restraints.

h.

Other non-routine nursing care given;

i.

The condition of a resident upon discharge; and

j.

The time of death, the physician called, and the person to whom the body was released.

(d)

Social service records. Notes regarding pertinent social data and action taken.

(e)

Activities records. Documentation of activities programming, a summary of attendance, and quarterly progress notes.

(f)

Rehabilitative services. 1. An evaluation of the rehabilitative needs of the resident; and 2. Progress notes detailing treatment given, evaluation, and progress.

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An evaluation of the rehabilitative needs of the resident; and

2.

Progress notes detailing treatment given, evaluation, and progress.

(h)

Dental services. Records of all dental services.

(i)

Diagnostic services. Records of all diagnostic tests performed during the resident's stay in the facility.

(j)

Plan of care. Plan of care required by s. DHS 132.60(8).

(k)

Authorization or consent. A photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident and any resident consent form required under this chapter, except that if the authorization or consent form exceeds one page in length an accurate summary may be substituted in the resident record and the complete authorization or consent form shall in this case be maintained as required under sub. (6) (i). The summary shall include: 1. The name and address of the guardian or other person having authority to speak or act on behalf of the resident; 2. The date on which the authorization or consent takes effect and the date on which it expires; 3. The express legal nature of the authorization or consent

and any limitations on it; and 4. Any other factors reasonably necessary to clarify the scope and extent of the authorization or consent.

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The name and address of the guardian or other person having authority to speak or act on behalf of the resident;

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The date on which the authorization or consent takes effect and the date on which it expires;

3.

The express legal nature of the authorization or consent and any limitations on it; and

4.

Any other factors reasonably necessary to clarify the scope and extent of the authorization or consent.

(L)

Discharge or transfer information. Documents, prepared upon a resident's discharge or transfer from the facility, summarizing, when appropriate: 1. Current medical findings and condition; 2. Final diagnoses; 3. Rehabilitation potential; 4. A summary of the course of treatment; 5. Nursing and dietary information; 6. Ambulation status; 7. Administrative and social information; and 8. Needed continued care and instructions.

1.

Current medical findings and condition;

2.

Final diagnoses;

3.

Rehabilitation potential;

4.

A summary of the course of treatment;

5.

Nursing and dietary information;

6.

Ambulation status;

7.

Administrative and social information; and

8.

Needed continued care and instructions.

(6)

OTHER RECORDS. The facility shall retain: (a) Dietary records. All menus and therapeutic diets; (b) Staffing records. Records of staff work schedules and time worked; (c) Safety tests. Records of tests of fire detection, alarm, and extinguishment equipment; (d) Resident census. At least a weekly census of all residents, indicating numbers of residents requiring each level of care; (e) Professional consultations. Documentation of professional consultations by: 1. A dietitian, if required by s. DHS 132.63(2) (b); 2. A registered nurse, if required by s. DHS 132.62(2); and 3. Others, as may be used by the facility; (f) Inservice and orientation programs. Subject matter, instructors and attendance records of all inservice and orientation programs; (g) Transfer agreements. Transfer agreements, unless exempt under s. DHS 132.53(4); (h) Funds and property statement. The statement prepared upon a resident's discharge or transfer from the facility that accounts for all funds and property held by the facility for the resident. (i) Court orders and consent forms. Copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the resident.

(a)

Dietary records. All menus and therapeutic diets;

(b)

Staffing records. Records of staff work schedules and time worked;

(c)

Safety tests. Records of tests of fire detection, alarm, and extinguishment equipment;

(d)

Resident census. At least a weekly census of all residents, indicating numbers of residents requiring each level of care;

(e)

Professional consultations. Documentation of professional consultations by: 1. A dietitian, if required by s. DHS 132.63(2) (b); 2. A registered nurse, if required by s. DHS 132.62(2); and 3. Others, as may be used by the facility;

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A registered nurse, if required by s. DHS 132.62(2); and

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Others, as may be used by the facility;

(f)

Inservice and orientation programs. Subject matter, instructors and attendance records of all inservice and orientation programs;

(g)

Transfer agreements. Transfer agreements, unless exempt under s. DHS 132.53(4);

(h)

Funds and property statement. The statement prepared upon a resident's discharge or

transfer from the facility that accounts for all funds and property held by the facility for the resident.

(i)

Court orders and consent forms. Copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the resident.