(c) Standard: Client Records

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W110

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§483.410(c)(1) The facility must develop and maintain a record keeping system that includes a separate record for each client and;

W111

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§483.410(c)(1) that documents the client's health care, active treatment, social information, and protection of the client's rights.

Guidance §483.410(c)(1)

The structure and content of a client's record must be an accurate, functional representation of the actual experience of the client in the facility.

The record should contain an accurate account of all information relevant to the client's health care, active treatment, social information and protection of the client's rights, such as communications, correspondence, program plans (to include both in-house and outside service programs), progress summaries, activity plans and activity participation, incidents, consent forms and all medical information.

If the records are maintained electronically, the facility staff should be able to access various parts of the record without difficulty. If they are unable to access components of the record upon request, then this may indicate a lack of training by the facility.

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§483.410(c)(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

Guidance §483.410(c)(2)

"Keep confidential" means safeguarding the content of information including video, audio, and/or computer stored information from unauthorized disclosure without the specific informed consent of the client, parent of a minor child, or legal guardian, and consistent with the advocate's right of access. Facility staff and consultants, hired to provide services to the client, sign confidentiality agreements before having access to client records and should have access to only that portion of information that is necessary to provide effective responsive services to the client.

These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

The facility has in place safeguards to ensure that access to all information regarding clients is limited to those clients designated by Health Insurance Portability and Accountability Act (HIPAA) requirements, the Developmental Disabilities Act, State law and facility policy.

The facility should prevent any instances of unauthorized access or dissemination. For example, the staff is observed to leave the client record (hard copy or electronic version) in the living room of the house when visitors or persons not authorized to access client records are present. Client records must be secured when staff is not present.

The facility must develop and follow procedures for maintaining the confidentiality of client information during transport to medical appointments or to other locations outside the facility.

Confidentiality applies to both central records and information kept at dispersed locations. If there is information considered too confidential to place in the record used by all staff (e.g., identification of the family's financial assets, sensitive medical

data), it may be retained in a companion record located in a secure location in the facility with a notation made in the primary record as to the location of confidential information. The facility must ensure that any client information provided to day services programs is maintained confidential.

The sharing of client specific information with members of the "specially constituted committee" required by §483.440(f)(3), who are not affiliated with the agency, does not violate a client's right to have information about him or her kept confidential. The committee must have relevant information to function properly.

Facility confidentiality safeguards include the development and implementation of written policies to assure that members of the specially constituted team maintain confidentiality. Such processes may include signed confidentiality agreements.

These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

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§483.410(c)(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

Guidance §483.410(c)(3)

The facility develops and follows written policies governing the release of client information.

Release of any personally identifiable information does not occur unless consent(s) is obtained prior to the release.

These policies must address at a minimum who must give consent for the release of information from records. The policy and procedures should account for other situations involving the release of client information, such as:

who should be notified when records have been released; procedures to be followed with subpoenas; time frames for providing requested information; and information regarding a client's HIV status may not be released without specific consent and may not be in the record if that consent has not been given.

W114

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§483.410(c)(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

Guidance §483.410(c)(4)

Illegible writing in hard copy records can contribute to communication deficits among staff. Illegible writing which cannot be easily interpreted by facility staff upon surveyor request may constitute a safety issue.

Electronic signatures are acceptable in the electronic record system.

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§483.410(c)(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.

W116

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§483.410(c)(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.

Guidance §483.410(c)(6)

"Appropriate" means those parts of each client's record are most likely (or known) to be needed by the residential staff to carry out the client's active treatment program in the unit; to alert staff to health risks and other aspects of medical treatment; to support the psychosocial needs of the client; to contact family or emergency contacts, and to provide anything else necessary to the staff's ability to work on behalf of the client.

The staff of the residential living unit has, and can access, all information which is relevant to implementing client program plans, appropriate care of, interaction with, and provision of services for the client.