Section 751.7 - Medical record system

751.7 Medical record system. The operator shall:

(a) maintain a medical record system;

(b) designate a staff member who has overall supervisory responsibility for the medical record system;

(c) ensure that the medical record supervisor receives consultation from a qualified medical record practitioner when such supervisor is not a qualified medical record practitioner;

(d) ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient, justifies the treatment and documents the results of such treatment;

(e) ensure that the following are included in the patient's record as appropriate:

(1) patient identification information;

(2) consent forms;

(3) medical history;

(4) immunization and drug history with special notation of allergic or adverse reactions to medications;

(5) physical examination reports;

(6) diagnostic procedures/tests reports;

(7) consultative findings;

(8) diagnosis or medical impression;

(9) medical orders;

(10) psychosocial assessment;

(11) documentation of the services provided and referrals made;

(12) anesthesia record;

(13) progress note(s);

(14) follow-up plans; and

(15) discharge summaries, when applicable;

(f) ensure that entries in the medical record are current, legible, signed and dated by the person making the entry;

(g) ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons;

(h) ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record;

(i) maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff; and

(j) retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer.