10A NCAC 13B .3905 PATIENT MEDICAL RECORDS

(a) Hospital management shall maintain medical records for each patient treated or examined in the facility.

(b) The medical record or medical record system shall provide data for each episode of care and treatment rendered by the facility.

(c) Where the medical record does not combine all episodes of inpatient, outpatient and emergency care, the medical records system shall:

(1) assemble, upon request of the physician, any or all divergently located components of the medical record when a patient is admitted to the facility or appears for outpatient or clinic services; or

(2) require placing copies of pertinent portions of each inpatient's medical record, such as the discharge resume, the operative note and the pathology report, in the outpatient or combined outpatient emergency unit record file as directed by the medical staff.

(d) The manager of medical records shall ensure that:

(1) each patient's medical record is complete, readily accessible and available to the professional staff concerned with the care and treatment of the patient;

(2) all clinical information pertaining to a patient is incorporated in his medical record;

(3) all entries in the record are dated and authenticated by the person making the entry;

(4) symbols and abbreviations are used only when they have been approved by the medical staff and when there exists a legend to explain them;

(5) verbal orders include the date and signature of the person recording them. They shall be given and authenticated in accordance with the provisions of Rule .3707(c) of this Subchapter; and

(6) records of patients discharged are completed within 30 days following discharge or disciplinary action is initiated as defined in the medical staff bylaws.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
Eff. January 1, 1996;
Amended Eff, April 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.