10A NCAC 13S .0321 MEDICAL RECORDS

(a) The clinic shall maintain a complete and permanent record for all patients including:

(1) the date and time of admission and discharge;
(2) the patient's full and true name;
(3) the patient's address;
(4) the patient's date of birth;
(5) the patient's emergency contact information;
(6) the patient's diagnoses;
(7) the patient's duration of pregnancy;
(8) the patient's condition on admission and discharge;
(9) a voluntarily-signed consent for each surgery or procedure and signature of the physician performing the procedure witnessed by a family member, other patient representative, or facility staff member;
(10) the patient's history and physical examination including identification of pre-existing or current illnesses, drug sensitivities or other idiosyncrasies that may impact the procedure or anesthetic to be administered; and
(11) documentation that indicates all items listed in Rule .0320(d) of this Section were provided to the patient.

(b) The clinic shall record and authenticate by signature, date, and time all other pertinent information such as pre- and post-procedure instructions, laboratory reports, drugs administered, report of abortion procedure, and follow-up instruction, including family planning advice.

(c) If Rh is negative, the clinic shall explain the significance to the patient and shall record the explanation. The patient in writing may reject Rh immunoglobulin. A written record of the patient's decision shall be a permanent part of her medical record.

(d) An ultrasound examination shall be performed by a technician qualified in ultrasonography and the results, including gestational age, placed in the patient's medical record for any patient who is scheduled for an abortion procedure.

(e) The clinic shall maintain a daily procedure log of all patients receiving abortion services. This log shall contain at least the following:

(1) the patient name;
(2) the estimated length of gestation;
(3) the type of procedure;
(4) the name of the physician:
(5) the name of the Registered Nurse on duty; and
(6) the date and time of procedure.

(f) Medical records shall be the property of the clinic and shall be preserved or retained in the State of North Carolina for a period of not less than 10 years from the date of the most recent discharge, unless the client is a minor, in which case the record must be retained until three years after the client's 18th birthday, regardless of change of clinic ownership or administration. Such medical records shall be made available to the Division upon request and shall not be removed from the premises where they are retained except by subpoena or court order.

(g) The clinic shall have a written plan for destruction of medical records to identify information to be retained and the manner of destruction to ensure confidentiality of all material.

(h) Should a clinic cease operation, the clinic shall arrange for preservation of records for at least 10 years. The clinic shall send written notification to the Division of these arrangements.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024.