10A NCAC 13C .1002 INDIVIDUAL PATIENT RECORDS

(a) Each patient's medical record shall be maintained in accordance with professional standards and shall include at least the following information:

(1) patient's identification, including name, address, date of birth, next of kin and a patient number;
(2) admitting diagnosis;
(3) preoperative history and physical examination pertaining to the procedure to be performed;
(4) anesthesia report;
(5) surgeon's operative report;
(6) anesthesiologist's or anesthetist's report if applicable;
(7) pertinent laboratory, pathology and X-ray reports;
(8) postoperative orders and follow-up care;
(9) discharge summary, including discharge diagnosis;
(10) record of informed consent; and
(11) physician's, dentist's, and nurse's progress notes.

(b) The administrator shall be responsible for safeguarding information on the medical record against loss, tampering, or use by unauthorized persons.

(c) Medical records shall be the property of the facility and shall not be moved from the premises wherein they are filed except by subpoena or court order.

(d) For licensing purposes the length of time that medical records are to be retained is dependent upon the need for their use in continuing patient care and for legal, research, or educational purposes. This length of time shall not be less than 20 years.

(e) Should a facility cease operation, there shall be an arrangement for preservation of records to insure compliance with these regulations. The Department shall be notified, in writing, concerning the arrangements.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.