10A NCAC 26D .0703 RECORD REQUIREMENTS

(a) A written client record shall be maintained for each client, and shall contain, at a minimum, the following identifying information:

(1) name;
(2) record number;
(3) date of birth;
(4) race, sex, and marital status;
(5) admission date; and
(6) discharge date.

(b) Active outpatient client records shall be kept in the outpatient health record and filed at the client's assigned unit.

(c) Each inpatient program shall maintain active inpatient records which shall be kept separate from the outpatient records.

(d) The outpatient record shall be transferred to the inpatient unit.

(e) Information required in other rules in this Subchapter, including but not limited to, prescribing and administering medication, and seclusion and restraint shall be documented in the client record.

(f) All client record entries shall include the date of entry and authentication by the individual making the entry.

(g) The time of service shall be recorded, based upon the nature of the service or incident, such as, shift notes, medication administration, and accidents and injuries.

(h) All client record entries shall be legible and made in permanent ink or typewritten.

(i) Alterations in client records, which are necessary in order to correct recording errors or inaccuracies, shall:

(1) be made by the individual who recorded the entry;
(2) have a single, thin line drawn through the error or inaccurate entry with the original entry still legible;
(3) show the corrected entry legibly recorded above or near the original entry;
(4) show the type of documentation error or inaccuracy whenever the reason for the alteration is unclear; and
(5) include the date of correction and initials of recorder.

(j) Each page of the client record shall include the client's name and number.

(k) Client records shall include only those symbols and abbreviations contained in an abbreviation list approved by the Department.

(l) Notations in a client's record shall not identify another client by name.

(m) Each service delivery site shall designate, in writing, those individuals authorized to have access to client records and who may make entries in the record.

(n) Any additional information regarding the following shall be included in the client record:

(1) diagnostic tests, assessments, evaluation, consultations, referrals, support services or medical services provided;
(2) known allergies or hypersensitivities;
(3) major events, accidents or medical emergencies, involving the client;
(4) consent for, and documentation of, release of information;
(5) documentation of applied behavior modification, which includes at risk or other intrusive interventions, including authorization, duration, summaries of observation and justification;
(6) conferences or involvements with the client's family, significant others, or involved agencies or service providers;
(7) documentation of attendance in outpatient service; and
(8) results of any standardized and non-standardized evaluations, such as social, developmental, medical, psychological, vocational or educational.

History Note: *Authority G.S. 148-19(d);*
Eff. January 4, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.