10A NCAC 70I .0506 CLIENT RECORDS

(a) A residential child-care facility shall maintain a client record for each child that contains the following:

(1) documentation of placement authority by parents, guardian, or legal custodian;
(2) written placement consent and agreement;
(3) intake study and related documents;
(4) the completed application for services that includes demographic information on the child and the child's family;
(5) documentation that verifies the child's birth;
(6) the pre-admission medical examination report or a medical examination report completed within two weeks of admission (unless the child's health indicates the completion of a medical examination report sooner) and copies of subsequent medical examination reports;
(7) immunization records;
(8) the out-of-home family services agreement and reviews;
(9) any court orders;
(10) visitation and contact plan, including type, duration, location both on-site and off-site, and frequency, as well as any rationale for restrictions on family involvement;
(11) documentation of all visitation;
(12) consents for release of information;
(13) consent for emergency medical treatment;
(14) consents for overnight activities outside the direct supervision of the caregiver for periods exceeding 72 hours;
(15) consents for time-limited audio-visual recording signed by both the child and parents or guardian, and legal custodian (if applicable);
(16) ongoing record of medical and dental care;
(17) documentation of medical insurance;
(18) progress notes;
(19) a discharge summary including date of discharge, time of discharge and the name, address, telephone number and relationship of the person or agency to whom the child was discharged, a summary of services provided during care, needs that remain to be met, and plans for the services needed to meet these goals;
(20) medical reports including medical history, cumulative health history, and available psychological and psychiatric reports, and, if applicable:
    (A) documentation of mental illness, developmental disabilities, or substance abuse diagnosis coded in accordance with the Diagnostic and Statistical Manual of Mental Disorders that was current at the time of diagnosis. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"), which is incorporated by reference, including subsequent amendments and editions, may be purchased from the American Psychiatric Association at cost of two hundred and ten dollars ($210.00) at https://www.psychiatry.org/psychiatrists/practice.dsm;
    (B) documentation of screening and assessment;
    (C) medication orders and Medication Administration Record (MAR);
    (D) documentation of medication administration errors;
    (E) documentation of adverse drug reactions; and
    (F) orders and copies of lab tests;
(21) documentation of searches for drugs, weapons, contraband, or stolen property, including date and time of the search, action taken by direct care staff, the date and time the direct care staff informed the residential child-care facility of the search, and the date and time of the notification to the child's parents, guardian, or legal custodian; and
(22) authorization from the parents, guardian, legal custodian, or licensed medical provider to administer non-prescription medications.

(b) Staff members recording entries in client records shall sign or initial and date entries.

History Note: *Authority G.S. 131D-10.2A; 131D-10.5; 143B-153;*
Eff. July 1, 1999 (See S.L. 1999, c. 237, s. 11.30);
Amended Eff. October 1, 2008; July 18, 2002;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. April 5, 2016;
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