

10A NCAC 13J .1402 CONTENT OF RECORD

(a) If the agency is providing services to a client which do not require a physician's order, the service record shall contain the following information at a minimum:

- (1) Admission data:
 - (A) identification data such as name, address, telephone number, date of birth, sex, marital status, social security number; all information essential to the identification of the client; and a copy of the signed client's right's form or documentation of its delivery;
 - (B) names of next of kin or legal guardian;
 - (C) names of other family members;
 - (D) source of referral; and
 - (E) assessment of home environment.
- (2) Service data:
 - (A) initial assessments by appropriate professional of the client's functional status in the areas of social, mental, physical health, environmental, economic, activities of daily living and instrumental activities of daily living;
 - (B) identification of problems, the establishment of goals and proposed intervention and indication of the client's understanding of and approval for services to be provided. If the client is not competent to understand the treatment plan, the approval of the client's responsible party shall be recorded;
 - (C) a record of all services provided, directly and by contract, with entries dated and signed by the individual providing the service. Records shall include dates and times of services provision;
 - (D) discharge summary which includes an overall summary of services provided by the agency and the date and reason for discharge. When a specific service to a client is terminated and other services continue, there shall be documentation of the date and reason for terminating the specific service; and
 - (E) evidence of coordination of services when the client is receiving more than one home care service.

(b) If the agency is providing services to a client which require a physician's order, the service record shall include at a minimum all of the items described in Paragraph (a) of this Rule and the following items:

- (1) Admission data:
 - (A) admission and discharge dates from hospital or other institution when applicable; and
 - (B) names of physician(s) responsible for the client's care.
- (2) Service data:
 - (A) client's diagnoses;
 - (B) physician's orders for pharmaceuticals and medical treatments; and
 - (C) If the agency is providing services to a hospital or nursing facility patient, the agency's record shall include at a minimum the following items:
 - (i) referral information;
 - (ii) dates and times of services; and
 - (iii) documentation of services provided.

*History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. February 1, 1996.*