10A NCAC 13J .1402  CONTENT OF RECORD

(a) If the agency is providing services to a client, the service record shall contain the following information:

(1) Admission data:
(A) identification data such as name, address, telephone number, date of birth, sex, and marital status;
(B) a copy of the signed client's rights form or documentation of its delivery;
(C) names of next of kin, legal guardian, or other family members;
(D) source of referral; and
(E) assessment of home environment.

(2) Service data:
(A) initial assessments by the health care practitioner of the client's functional status in the areas of social, mental, physical health, environmental, economic, ADLs, and IADLs;
(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 diagnosed as not competent, the approval of the client's responsible party shall be recorded;
(C) a record of all services provided with entries with date and time of service, and signed by the individual providing the service;
(D) discharge summary that 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 in-home care service.

(b) If the agency is providing services to a client that require a physician's order, the service record shall include 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 referral information, dates and times of services, and documentation of services provided.

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