3701-19-23 **Central clinical record.**

(A) Each hospice care program shall establish and maintain a central clinical record for each hospice patient receiving care and services from the program and his or her family. The record shall be established and maintained in accordance with accepted standards of practice.

(B) The clinical record shall be a comprehensive compilation of information that is documented promptly for all services provided. The record shall be organized systematically to facilitate retrieval of information~~.~~ and meet the following requirements: ~~Entries to the clinical record shall be made and signed by the person providing the service. All services, whether furnished by employees, persons under contract, or volunteers, shall be documented in the clinical record. Entries in the clinical record shall be dated and shall be made within a responsible period of time after the services were provided.~~

(1) Documentation of all services provided, whether furnished by employees, persons under contract, or volunteers;

(2) Documentation shall be dated and be made within a responsible period of time after the services were provided; and

(3) Entries to the clinical record shall be made and signed by the person providing the service.

(C) Each clinical record shall contain at least the following information:

(1) Identification data;

(2) Pertinent medical history, including the physician's diagnosis of terminal illness;

(3) Consent and authorization forms;

(4) Initial and subsequent assessments that include evaluations of physical, psychosocial, nutritional, and spiritual needs, if any, and the need for volunteer or bereavement services;

(5) The interdisciplinary plan of care;

(6) Documentation of all services and events, such as evaluations, treatments, and progress notes;

(7) A statement of whether or not the patient, if an adult, has prepared an advanced directive. "Advanced directive" has the same meaning as "declaration" as defined in section 2133.01 of the Revised Code; and

(8) Transfer and discharge summaries.

(D) The hospice care program shall provide for storage of the central clinical records to protect them against loss, destruction, and unauthorized use. The program also shall have policies and procedures to ensure the confidentiality of records.

(E) A hospice care program which maintains a patient's clinical record electronically shall use an electronic signature system that meets the requirements specified under division (B) of section 3701.75 of the Revised Code. Electronic patient clinical records shall be accessible to the director during inspections.

Effective:	1/23/2020
Five Year Review (FYR) Dates:	11/6/2019 and 01/13/2025

CERTIFIED ELECTRONICALLY

Certification

01/13/2020

Date

Promulgated Under:	119.03
Statutory Authority:	3712.03; 3712.10
Rule Amplifies:	3712.01, 3712.03, 3712.06
Prior Effective Dates:	12/31/1990, 10/17/1999, 08/23/2009, 02/15/2015