481—53.20(135J) Records. In accordance with accepted principles of medical record practice, each hospice shall maintain a centralized complete record on every individual receiving services. This record shall be preserved for at least six years following termination of services.

53.20(1) Each entry shall be dated and signed, including the name and title of the person who makes the entry.

53.20(2) The record shall include documentation of all services provided, whether furnished by the hospice or by contractual agreement. Each record shall include, but not be limited to:

a. Patient identification and demographic data;
b. Initial and subsequent assessments;
c. The plan of care;
d. Medical history;
e. Documentation of all services provided;
f. Consent and authorization forms;
g. Physicians' orders;
h. Medication records;
i. Discharge summary; and
j. Discharge and transfer records.

53.20(3) The hospice shall have written and implemented policies to safeguard destruction or unauthorized use of patient records. Written procedures shall govern use and removal of records, conditions for release of information and identification by title of the person who may release records.

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