Centers for Medicare & Medicaid Services, HHS § 418.104

§ 418.104 Condition of participation: Clinical records.

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient’s attending physician and hospice staff. The clinical record may be maintained electronically.

(a) Standard: Content. Each patient’s record must include the following:
   (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
   (2) Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with §418.24.
   (3) Responses to medications, symptom management, treatments, and services.
   (4) Outcome measure data elements, as described in §418.54(e) of this subpart.
   (5) Physician certification and recertification of terminal illness as required in §§418.22 and 418.25 and described in §§418.102(b) and 418.102(c) respectively, if appropriate.
   (6) Any advance directives as described in §418.52(a)(2).
   (7) Physician orders.

(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.

(c) Standard: Protection of information. The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department’s rules regarding personal health information as set out at 45 CFR parts 160 and 164.

(d) Standard: Retention of records. Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.

(e) Standard: Discharge or transfer of care. (1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward to the receiving facility, a copy of—
   (i) The hospice discharge summary; and
   (ii) The patient’s clinical record, if requested.
   (2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient’s attending physician, a copy of—
   (i) The hospice discharge summary; and
   (ii) The patient’s clinical record, if requested.
   (3) The hospice discharge summary as required in paragraph (e)(1) and (e)(2) of this section must include—
   (i) A summary of the patient’s stay including treatments, symptoms and pain management.
   (ii) The patient’s current plan of care.
   (iii) The patient’s latest physician orders, and
   (iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

(f) Standard: Retrieval of clinical records. The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.