Kansas Administrative Regulations

Department of Health and Environment

Article 34.—Hospitals—Part 1. General.

28-34-9a. Medical records services.

(a) General provisions. Each hospital shall maintain medical records for each patient admitted for care. The records shall be documented and readily retrievable by authorized persons.

(b) Organization and staffing.

(1) Each hospital shall have a medical records service that is directed, staffed, and equipped to enable the accurate processing, indexing, and filing of all medical records. The medical records service shall be under the direction of a person who is a registered health information administrator or a registered health information technician as certified by the American health information management association, or who meets the educational or training requirements for this certification.

(2) If the employment of a full-time registered health information administrator or registered health information technician is impossible, the hospital shall employ a registered records administrator or an accredited records technician on a part-time consultant basis. The consultant shall organize the department, train full-time personnel, and make periodic visits to evaluate the records. There shall be a written contract between the hospital and the consultant that specifies the consultant's duties and responsibilities.

(3) At least one full-time employee shall provide regular medical records service.

(c) Facilities. The medical records department shall be properly equipped to enable its personnel to function in an effective manner and to maintain medical records so that the records are readily accessible and secure from unauthorized use.

(d) Policies and procedures.

(1) Each medical record shall be kept on file for 10 years after the date of last discharge of the patient or one year beyond the date that the minor patient reached the age of majority, whichever is longer.

(2) If a hospital discontinues operation, the hospital shall inform the licensing agency of the location of its records.

(3) A summary shall be maintained of medical records that are destroyed. This summary shall be retained on file for at least 25 years and shall include the following information:

(A) The name, age, and date of birth of the patient;

(B) the name of the patient's nearest relative;

(C) the name of the attending and consulting practitioners;

(D) any surgical procedure and date, if applicable; and

(E) the final diagnosis.

(4) Medical records may be microfilmed after completion. If the microfilming is done off the premises, the hospital shall take precautions to assure the confidentiality and safekeeping of the records.

(5) Each record shall be treated as confidential. Only persons authorized by the governing body shall have access to the records. These persons shall include individuals designated by the licensing agency for the purpose of verifying compliance with state or federal statutes or regulations and for disease control investigations of public health concern.

(6) Medical records shall be the property of the hospital and shall not be removed from the hospital premises except as authorized by the governing body of the hospital or for purposes of litigation when specifically authorized by Kansas law or appropriate court order.

(e) Contents of medical records. Medical records shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. At a minimum, each record shall include the following:

(1) Notes by authorized house staff members and individuals who have been granted clinical privileges, consultation reports, nurses' notes, and entries by designated professional personnel;

(2) findings and results of any pathological or clinical laboratory examinations, radiology examinations, medical and surgical treatment, and other diagnostic or therapeutic procedures; and

(3) provisional diagnosis, primary and secondary final diagnosis, a clinical resume, and, if appropriate, necropsy reports.

(f) Each entry in each record shall be dated and authenticated by the person making the entry. Verbal orders, including telephone orders, shall include the date and signature of the person recording them. The prescribing or covering practitioner shall authenticate the order within 72 hours of the patient's discharge or 30 days, whichever occurs first. Records of patients discharged shall be completed within 30 days following discharge.

(Authorized by and implementing K.S.A. 65-431; effective May 1, 1986; amended June 28, 1993; amended Feb. 9, 2001.)

***** Authenticated Kansas Administrative Regulation *****