

Kansas Administrative Regulations

Department of Health and Environment

Article 51.—Home Health Agency Licensure

28-51-110. Clinical records and client records.

(a) General provisions. A clinical record or client record containing pertinent past and current findings shall be maintained in accordance with accepted professional standards for each patient or client receiving home health services.

(b) Content of clinical record. Each clinical record shall contain at least the following:

(1) The patient's plan of care;

(2) the name of the patient's physician, nurse practitioner, clinical nurse specialist, or physician assistant;

(3) drug, dietary, treatment, and activity physician orders;

(4) signed and dated admission notes and clinical notes that are written the day the home health service is rendered and incorporated at least weekly;

(5) documentation of home health services provided, date and time in and out, and a confirmation that home health services were provided;

(6) documentation that HCBS were performed according to policies and guidelines for HCBS, if the home health agency provides HCBS;

(7) a copy of all progress notes;

(8) the date of each on-site visit for supervision required by K.A.R. 28-51-118; and

(9) the discharge summary report.

(c) Content of client record. Each client record shall contain at least the following:

(1) The plan of care;

(2) the name of the client's physician, nurse practitioner, clinical nurse specialist, or physician assistant;

(3) physician orders for drugs, diet, treatment, and activity;

(4) signed and dated admission notes;

(5) documentation of supportive care services provided, the date and time the provider of supportive care services checked in and out, and a confirmation that supportive care services were provided;

(6) a copy of progress notes;

(7) the date of each on-site visit for supervision required by K.A.R. 28-51-117; and

(8) the discharge summary report.

(d) Retention. Each clinical record and each client record shall be retained in a retrievable form for at least five years after the date of the last discharge of the patient or client. If the licensee discontinues operation, provision shall be made for retention of records.

(e) Safeguard against loss or unauthorized use. Written policies and procedures shall be developed regarding the use and removal of documents from the patient record or client record and the conditions for release of information. The patient's, client's, or guardian's written consent shall be required for release of information not required by law.

(Authorized by K.S.A. 65-5109; implementing K.S.A. 65-5104; effective, T-86-23, July 1, 1985; effective May 1, 1986; amended Feb. 28, 1994; amended May 20, 2022.)

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