

RESIDENT RECORDS



PURPOSE & KEY TERMS

- The purpose is to assist the learner in understanding how to set up effective resident records, what information must be included in the resident record, how to maintain confidentiality and provide an overview of the mandatory forms.
- Confidentiality
- Long term care assessment
- Mandatory forms
- Physician or Nurse Practitioner's orders

OBJECTIVES

- After completing this section the learner will be able to:
 - ❑ List the type of information and documents that must be included in the resident's record.
 - ❑ Describe the purpose of the mandatory forms and suggested supplemental forms.
 - ❑ Define who is required to have a long term care assessment.
 - ❑ Understand what requires a physicians' or nurse practitioners' medical order.

INTRODUCTION

- In addition record keeping required to run a business in Oregon; AFH rules require additional record keeping specific to the AFH setting:
 - Setting up a records system prior to admitting residents makes the process of screening and admission easier and more accurate.
 - Well-organized records makes the information more usable for you, your staff and APD or other professionals who need access to the records.

RESIDENT RECORD

- Individual records must be up-to-date and on the premises. Access must be available to:
 - ❑ The resident;
 - ❑ All caregivers;
 - ❑ APD staff conducting inspections/investigations; and
 - ❑ Oregon's LTCO.
- Resident records are confidential and cannot be seen by anyone (except as listed above) without written authorization from the resident or a legal representative.

RESIDENT RECORD CONTINUED

- Required resident's record documents:
 - **Screening and general information should be gathered during the initial screening utilizing SDS 902 and SDS 034:**
 - Refer to OAR 411-50-0655 (2).
 - **Medical history:** Medical history about a resident prior to admission to your home can be valuable in determining if you can meet their needs. *The resident may need to sign a release of information;*

RESIDENT RECORD CONTINUED

- ❑ **Current signed medical orders:** For every resident and every prescribed medication, dietary supplement, treatment and/or therapy. *Medical Visit Report form (SDS 0341);*
- ❑ **Care plan:** Each resident must have an individualized care plan that reflects the resident's choices and maximize independence. *SDS 0340:*
 - *Refer to [OAR 411-015-0006](#) for the complete definition for each ADL.*
- ❑ **Documentation of RN delegation:**
 - If tasks of nursing are performed by a lay caregiver specific documentation must be left at the AFH by the delegating RN;

RESIDENT RECORD CONTINUED

- ❑ **Copies of letters of conservatorship or guardianship, and health care directives** such as the Advance Directive, POLST and Power of Attorney for Health Care. Residents are not required to have any of these, but if they do it must be in the resident's record;
- ❑ **Past six months' medication administration records (MARs):** Keep MARs in the resident's file for a minimum of six months. After six months, the forms should be filed in a separate storage place. ***SDS 812A;***

RESIDENT RECORD CONTINUED

- ❑ **Signed house rules:** Must be reviewed with the resident or their representative and a signed copy placed in the resident's record:
 - If your house rules change, you must discuss the changes with every resident and each resident must sign the new rules.

- ❑ **Written incident report:** is required if something happens regarding the resident's health/safety:
 - The incident report must identify how and when the incident occurred, who was involved, what action was taken and the outcome to the resident. **OAR 411-50-0655.**

RESIDENT RECORD CONTINUED

- ❑ **Weekly dated and signed narratives:**
 - At least once a week, the resident's progress must be documented in writing;
 - Notes must be signed and dated with the month, date and year; and
 - Narratives need to be individualized for every resident. Areas of progress for one resident may not be the same for another. *The notes made by outside professionals do not replace the narratives required of you and your staff.*

RESIDENT RECORD CONTINUED

- ❑ **Signed long-term care assessment form:** Prior to admission, you are required to advise private pay residents they are eligible to receive a long-term assessment. ***SDS 0913 Notice of Right to Received a Long-term Care Assessment.***

OTHER AFH FORMS

- ❑ **AFH Resident Records Checklist** was developed to assist AFH providers. The checklist is not required but the steps and information on the list must be completed. **SDS 348**
- ❑ **The emergency form** contains critical information, such as contact people for the resident, must be immediately available for use by emergency medical technicians (EMTs) and hospital personnel. Refer to 411-50-0655 for details regarding requirements. **SDS 0902A**

OTHER AFH FORMS CONTINUED

- ❑ **Food Likes and Dislikes** optional tool can be used as part of the screening process or after admission. **SDS 0902B**
- ❑ **Resident Personal Possessions:** You are not required to note the possessions a resident brings into the AFH. However, having a list will avoid problems later if there are questions about a resident's belongings. **SDS 346**

OTHER AFH FORMS CONTINUED

- ❑ **Notice of Move, Transfer or Discharge:** A resident can only be asked to leave your home for very specific reasons. Thirty days notice is required unless undue delay would jeopardize the resident or others in the home. *Refer to OAR 411-50-0645 for specific information. **SDS 901***
- ❑ **Documentation of Resident Orientation to Home:** You are required to orient the resident to the emergency procedures in your home. *Refer to OAR 411-50-0650 for specific information. **SDS 342A***

OTHER AFH FORMS CONTINUED

- ❑ **Transfers:** When a resident is transferred to a new place of residence you must send copies of all pertinent information with the resident. At a minimum, pertinent information must include:
 - Copies of current medication;
 - Administration records; and
 - An updated care plan.
- Resident records must be kept for three years after a person is no longer in your home.

DISCUSSION/QUESTIONS

