

K.A.R. 100-28b-14. Patient records. (a) Each licensee shall maintain an adequate health care record for each patient for whom the licensee performs a professional service.

(b) Each health care record shall meet the following requirements:

(1) Contain only those terms and abbreviations that are or should be comprehensible to similar licensees;

(2) document adequate identification of the patient;

(3) document all professional services provided or recommended and the date on which each professional service was provided or recommended;

(4) document all clinically pertinent information concerning the patient's condition;

(5) document all identifiable risk assessments performed on the patient;

(6) document all examinations, vital signs, and tests obtained, performed, or ordered, and the findings and results of each;

(7) document all medications prescribed, dispensed, or administered, the time each medication was prescribed, dispensed, or administered, and the dose and route of each medication;

(8) document the patient's response to all professional services performed or recommended;

(9) document all instruction and education provided to the patient related to the childbearing process;

(10) document the date and time of the onset of labor;

(11) document the course of labor, including all examinations and pertinent findings;

(12) document the date and exact time of birth, the presenting part of the newborn's

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body, the newborn's sex, and the newborn's Apgar scores;

(13) document the time of expulsion and the condition of the placenta;

(14) document the condition of the patient and newborn, including any complications and action taken;

(15) contain the results of all postpartum and newborn examinations;

(16) document all professional services provided to the newborn, including prescribed medications and the time, type, and dose of eye prophylaxis;

(17) contain documentation of all consultation and collaboration with a physician concerning the patient;

(18) contain documentation of each referral, transfer, and transport to a medical care facility, including the reasons for each referral, transfer, or transport to a medical care facility;

(19) contain all written instructions given to the patient regarding postpartum care, family planning, care of the newborn, arrangements for metabolic testing, immunizations, and follow-up pediatric care; and

(20) contain all pertinent health care records received from other health care providers.

(c) Each entry in the health care record shall meet the following requirements:

(1) Be legible; and

(2) be authenticated by the person making the entry. Each authentication in the health care record for an entry documenting professional services provided by an individual licensed to engage in the independent practice of midwifery shall include the letters "CNM-I" after the licensee's name.

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(d) For the purposes of the independent practice of midwifery act and this regulation, an electronic patient record shall be deemed a written patient record if both of the following conditions are met:

(1) Each entry in the electronic record is authenticated by the licensee.

(2) No entry in the electronic record can be altered after authentication. (Authorized by and implementing K.S.A. 65-28b07; effective P-_____.)

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