



ADMINISTRATIVE RULES OF MONTANA



37.106.2412 HOME INFUSION THERAPY AGENCY: MEDICAL RECORD

- (1) Each home infusion therapy agency shall establish and maintain for each patient accepted for care, a medical record which must be accessible to home infusion therapy personnel and which must include the following information:
 - (a) admission data, including the:
 - (i) name;
 - (ii) current address;
 - (iii) date of birth;
 - (iv) sex;
 - (v) date of admission;
 - (vi) name and contact information of the patient's caregiver or family member; and
 - (vii) name and contact information of the pharmacist-in-charge and the prescribing practitioner.
 - (b) admission diagnosis and pertinent health information relevant to the plan of care;
 - (c) any allergies and known adverse reactions to drugs and food. This information must be given such prominence in the record so as to make it obvious to any persons who provide food or medication to the patient;
 - (d) laboratory reports;
 - (e) documentation that a list of patient rights and responsibilities have been made available to each patient or the patient's caregiver;
 - (f) the plan of care;
 - (g) clinical assessments and services documentation;
 - (h) the prescribing practitioner's order for home infusion therapy;
 - (i) a monthly clinical therapy summary for any patient receiving services 30 days or longer; and
 - (j) a discharge summary of therapy at the end of treatment.
- (2) The responsibilities of the patient and the home infusion therapy agency, including any contracted parties, in the areas of delivery of care and monitoring of the patient, must be clearly documented in the patient's medical record.

- (3) The home infusion therapy agency, and any contracted party providing services to the patient, together, shall develop a plan of care within three working days of the initiation of therapy, which must include:
- (a) a diagnosis;
 - (b) the types of services and equipment required;
 - (c) the access device and route of administration;
 - (d) the estimated length of service;
 - (e) a statement of treatment goals;
 - (f) the regimen and prescription ordered;
 - (g) the concurrent legend and over the counter drugs;
 - (h) an assessment of mental status;
 - (i) permitted activities;
 - (j) the prognosis, discharge, transfer or referral plan; and
 - (k) instructions to patient and family.
- (4) All records of dispensed sterile pharmaceuticals must be a part of the patient's medical record.

Authorizing statute(s): 50-5-103, MCA

Implementing statute(s): 50-5-103, 50-5-213, MCA

History: NEW, 1996 MAR p. 2587, Eff. 10/4/96; TRANS, from DHES, 2002 MAR p. 185; AMD, 2009 MAR p. 1668, Eff. 9/25/09.