**Section 210.2600 Records and Reports**

a) Accurate and complete clinical records shall be maintained for each patient, and all entries in the clinical record shall be made at the time when care, treatment, medications or other medical services are given. The record shall include, but not be limited to, the following:

1) patient identification;

2) admitting information including the patient's history and physical examination findings, discharge summary from the ambulatory surgical treatment center or hospital where the surgical procedure was performed as required by Section 210.1800(a) of this Part;

3) signed physician, dentist, or podiatrist orders;

4) laboratory and radiology tests results;

5) medication and medical treatments;

6) physician and consultant or allied health personnel progress notes;

7) nursing observation, progress notes and vital sign charting;

8) discharge instructions and condition at discharge;

9) documentation concerning advance directives; and

10) signed discharge summary.

b) Records must be stored in a safe manner that will assure safety from water seepage or fire damage and will safeguard from unauthorized access.

c) All original records or copies of such records shall be maintained in accordance with a Postsurgical Recovery Care Center Model policy that complies with State and federal laws.

d) Each Postsurgical Recovery Care Center Model shall submit to the Department clinical statistical data that include the following:

1) the total number of patients admitted to the Postsurgical Recovery Care Center Model;

2) the number of patients admitted itemized by the surgical procedure and anesthesia class that was performed prompting the admission;

3) the number and type of complications, including the specific procedure associated with each complication;

4) the number of patients requiring transfer to another health care facility for treatment of complications or other reasons. List the procedure, type of health care facility, and the complication or reason which prompted each transfer; and

5) the number of deaths, including the surgical procedure performed prior to admittance and the events leading up to the patient's death.

e) This clinical data shall be submitted to the Department quarterly, with reports due no later than January 15, April 15, July 15, and October 15 for the preceding quarter.