

CHAPTER 16

Unit Health Record (UHR) Completion

I. POLICY

Unit health records shall be complete and accurate as they are developed, to facilitate quality health care, provide a communication tool for health care practitioners, expedite reporting of medical statistical data for health care management uses and provide a document to support the legal interests of the California Department of Corrections (CDC), the institution, the health care providers, and the patient.

Health care providers shall document the events of assessment, justification of diagnosis and treatment, timeliness and quality of health care provided, when and how care is provided and the outcomes of care. Health care providers shall record at the time of provision of services, or as close to the health care event as possible. Health care providers shall document in compliance with Medical Staff Bylaws, licensing regulations, Health Care Services Division policies, and accepted standards of practice. Inpatient records shall be completed within fourteen (14) days following discharge of the patient.

Health record staff shall monitor the completeness of UHR documentation.

II. PROCEDURE

- A. The HRT I shall perform analysis of all inpatient, ambulatory surgery, and outpatient housing health records, and shall monitor the completeness of data elements. Information reviewed for completeness during the review process shall include:
1. Patient identification: Name, date of birth and CDC number (addressograph imprint) on each document.
 2. Face sheet, or identification admission record, with patient demographics.
 3. History and physical examination reports.
 4. Evaluations, assessments.
 5. Progress notes written by each health care provider at the time of care, treatment, or services. Data collected during the provision of treatment, care or services, shall include information, as applicable for that encounter, such as: patient complaint; or reason for the service; onset of new symptoms or illness; clinical findings; diagnosis (update); treatment provided; management plan.
 6. Consultations, as applicable.
 7. Consents, including appropriate informed consent.
 8. Provider's orders for medications, diet, therapeutic interventions, and diagnostic testing.
 9. Results of diagnostic testing ordered.
 10. Nursing documentation:
 - a. Medication administration records.

- b. Nurses notes.
 - c. Care plan.
 - d. Graphic records.
 - e. Other forms designed to collect specific data element.
11. Signatures, titles. The printout of a computerized record shall be accepted as the original. These documents, which have been authenticated electronically, do not require additional signatures.
12. Dated and timed entries.
13. Chronos, as applicable, including the provider's order, time limitations, precautions, date, and signature.
- B. Discharge/Transfer of Patients from the Inpatient, Ambulatory Surgery, or Outpatient Housing Unit:
- 1. On a daily basis, the HRT I shall review the nursing census and daily movement sheet to identify patients who are:
 - a. Transferred out to the community.
 - b. Scheduled for transfer or discharge out of the institution.
 - 2. Notify the physician of the potential movement of patient, e.g., discharge/transfer:
 - a. Request dictation of the transfer or discharge summary.
 - b. Request discharge/transfer orders.
 - c. Arrange for the dictation to be transcribed immediately.
 - d. Arrange to obtain the provider's review and signature of the dictated report.
 - e. Remind all other health care providers of the need to expeditiously complete UHR documentation in preparation for record transfer. Impress upon health care staff the critical need to complete the record immediately since the UHR shall accompany the patient at the time of transfer to another institution.
 - 3. UHR documentation shall be complete, as the UHR shall accompany the patient at the time of transfer to another CDC institution.
 - a. The HRT I shall:
 - 1. Perform discharge/transfer analysis or final review prior to the patient's discharge from the inpatient status.
 - 2. Complete the usual discharge/transfer processes, e.g., coding, abstracting, preparation of record for transfer.
 - 3. Abstract discharge data information. Refer to policy: "Unit Health Record: Coding and Abstracting".
 - b. If the record is incomplete, the HRT I shall follow procedures in Chapter 3 for processing inpatient records. For all other records, follow the procedures below:
 - 1. Prepare the record for transfer.
 - 2. Copy only the pertinent portions of the record that are incomplete. Use these copies to obtain necessary data to complete the record.
 - 3. Follow institution transportation procedures.
 - 4. Work with providers to complete the record using the copies of the record. Incomplete portions shall be completed immediately, while information is easily recalled.

5. Notify the HCM and request assistance if any problems occur with timely completion.
 6. Forward the completed copies of the record containing the missing data elements directly to the HRS Supervisor at the receiving institution to ensure the completed portions are incorporated into the appropriate section of the UHR.
- C. Incomplete UHR files shall not be established:
1. When the record is not complete at the time of the patient's discharge from the inpatient, ambulatory surgery, or outpatient housing unit, the HRT I shall:
 - a. Identify missing data elements.
 - b. Identify on worksheets the providers responsible for record completion.
 - c. Use worksheets to follow up on incomplete status, daily.
 - d. Contact providers immediately. Notify providers of the need to complete records and to request prompt response. Use the established notification procedures.
 - e. Request that providers comply with signature requirements.
 - f. Arrange for providers' access to incomplete records. Make any necessary arrangements, e.g., hand carry, FAX information, make appointments or other arrangements. Inform the providers that health record staff is available to provide assistance.
 - g. Use the worksheets to retrieve records from the permanent file when the provider responds to the notification.
 - h. Be available to seek information needed.
 - i. Provide space within the health record work area for the provider to work.
 - j. Immediately reanalyze each record after the provider has finished with the record, preferably while the provider is still present.
 - k. Repeat above procedures as necessary.
 - l. If all deficiencies are corrected, remove worksheet from the control file and destroy the copy.
 - m. Update the cumulative worksheets.
 - n. If the providers do not respond to the first notification within 48 hours, renotify providers of incomplete records.
 - o. Take appropriate actions, e.g., notify the HCM if the provider does not respond to the second notice within 48 hours.
 2. Prepare reports for the HCM, and conduct quality management activities reflecting compliance with record completion policies and procedures.