

## **CHAPTER 27**

### **Content of Unit Health Record (UHR): Acute Care Inpatient**

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#### **I. POLICY**

The unit health record (UHR) must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the results accurately for each episode of care. The UHR serves as a basis for planning patient care and for continuity in the evaluation of the patient's condition. The content of the UHR must adequately document communication between responsible providers, and any other health professional contributing to the care of the patient. It also protects the legal interests of the patient, the health facility, and provider. Inpatient records shall be completed within fourteen (14) days following discharge of the patient.

The printout of a computerized record shall be accepted as the original. These documents, which have been authenticated electronically, do not require additional signatures.

#### **II. PROCEDURE**

Each health record for inpatient services shall consist of at least the following:

- A. Admission and discharge record identification data including, but not limited to, the following using CDC Form 7201:
  1. Name.
  2. Patient identification number.
  3. Date of birth.
  4. Sex.
  5. Marital status.
  6. Religion (optional on part of the patient).
  7. Date of admission.
  8. Date of discharge.
  9. Name, address and telephone number of person or agency responsible for the patient.
  10. Initial diagnostic impression.
  11. Discharge or final diagnosis(es).
- B. Mental Status.
- C. Emergency Room report (if applicable) which includes arrival information, diagnosis, chief complaint, objective findings, treatment, outcome, and disposition. [CDC Form 7286]
- D. Admission medical history and physical examination within 24-hours of admission. This shall include written documentation of a Mantoux tuberculin skin test within the past year, unless a previously positive reaction can be documented or completion of adequate preventive therapy or adequate therapy for active disease can be documented. If no

written documentation is available, the Mantoux tuberculin skin test shall be administered within 24-hours of admission, and recorded in millimeters of induration in the medical history. Physician shall dictate, or may use CDC Form 7206 for a handwritten history and physical examination report.

- E. Dated, timed, and signed observations and progress notes using the S.O.A.P.E. format including a working diagnosis, recorded at least every 24 hours, or as often as the patient's condition warrants by the person responsible for the care of the patient. [CDC Form 7230]
- F. Consultation reports, if applicable. [CDC Form 7243]
- G. Physician's orders for admission, activity, medication, treatment, testing, evaluation, consultation, diet, discharge, or other services. [CDC Form 7221]
- H. Social service evaluation, if applicable.
- I. Psychological evaluation, if applicable.
- J. Dated, timed, and signed health care notes including, but not limited to, the following:
  - 1. Patient care plan. [CDC Form 7216]
  - 2. Concise and accurate records of nursing care provided. [CDC Form 7212]
  - 3. Records of pertinent nursing observations of the patient and the patient's response to treatment.
  - 4. Record of type of restraint, including time of application and removal.
  - 5. Rehabilitation evaluation, if applicable.
  - 6. Interdisciplinary treatment plan, if applicable.
  - 7. Medication records including name, dosage, and time of administration of medications, and treatment given. The route of administration and site of injection shall be recorded if other than by oral administration. [CDC Form 7231]
  - 8. The reasons for the use of and the response of the patient to PRN medication administered and justification for withholding scheduled medications. [CDC Form 7231]
  - 9. Progress notes including the patient's response to medication and treatment rendered and observation(s) of the patient by all members of treatment team providing services to the patient. [CDC Form 7230]
  - 10. Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided.
  - 11. Vital sign record sheet. [CDC Form 7304, 7211]
  - 12. Consent forms as required, signed by the patient or the appropriate surrogate decision maker including Conditions of Admission/Placement, Consent for Surgical Procedures, and Consent for Special Procedures. [CDC Form 7293]
  - 13. Report of all surgical episodes to include:
    - a. Preanesthesia evaluation. [CDC Form 7209]
    - b. Anesthesia Report including pre-operative diagnosis
    - c. Intra-operative Record
    - d. Operative Report including pre-op and post-op diagnosis, description of findings, technique used, and tissue removed. [CDC Form 7205]

- e. Pathology Report, if tissue was removed.
- f. Post-operative anesthesia evaluation. [CDC Form 7209]
- 14. All dental records, if applicable.
- 15. Records of all laboratory tests, initialed and dated by a CDC physician. Abnormal results shall be documented in the progress notes along with documentation that the physician counseled the patient regarding abnormal result and treatment plan.
- 16. Reports of all cardiographic or encephalographic tests performed.
- 17. Reports of all radiologic examinations ordered.
- 18. All reports of special studies ordered.
- 19. Labor and Delivery records, if applicable.
- 20. A discharge summary prepared by the admitting or primary care practitioner who shall recapitulate the significant findings and events of patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care.
- 21. Discharge or transfer information and continuing care instructions.
- K. All health documentation received from transferring health facilities.