

## **CHAPTER 29**

### **Content of Unit Health Record (UHR): Skilled Nursing Facility (SNF)**

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#### **I. POLICY**

The 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.

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 skilled nursing 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 patient).
  7. Date of admission.
  8. Date of discharge.
  9. Name, address and telephone number of person or agency responsible for the inmate.
  10. Initial diagnostic impression.
  11. Discharge or final diagnosis(es).
- B. Mental Status.
- C. Emergency Room report (if applicable) which includes arrival information, chief complaint, objective findings, diagnosis, treatment, outcome, and disposition. [CDC Form 7286]
- D. Admission medical history and physical examination within 5 days prior to admission, or within 72 hours following 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. Current diagnoses
- F. Physician orders for admission, activity, medication, diagnostic tests, treatment, diet orders, and discharge, signed, dated, and timed, on each visit. [CDC Form 7221]
- G. Physician progress notes using the S.O.A.P.E. format documenting evaluation of the patient at least every 30 days, or as the patient's condition warrants. There must be a progress note documented for each physician visit. [CDC Form 7230]
- H. Nurses' notes which shall be signed, dated, and timed, and include:
  - 1. Records made by nurse assistants, after proper instruction, which shall include:
    - a. Care and treatment of the patient. [CDC Form 7216]
    - b. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health.
    - c. Notification to the licensed nurse of changes in the patient's condition.
  - 2. Dated, timed, and signed observations and progress notes recorded by licensed nurses as often as the patient's condition warrants. Weekly nurses' progress notes shall be written by licensed nurses on each patient, and shall be specific to the patient's needs, the patient care plan, and the patient's response to care and treatments. [CDC Forms 7230, 7212, 7212B]
  - 3. Patient care plan. [CDC Form 7216]
  - 4. Concise and accurate records of nursing care provided.
  - 5. 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. Medication and treatment records shall contain the name and professional title of staff signing by initials. [CDC Form 7231]
  - 6. The reasons for the use of and the response of the patient to PRN medication administered and justification for withholding scheduled medications. [CDC Form 7230]
  - 7. Record of type of restraint, including time of application and removal. The time of application and removal shall not be required for postural supports used for the support and protection of the patient.
  - 8. Documentation of oxygen administration.
- I. Dated, timed, and signed health care notes including, but not limited to, the following:
  - 1. Progress notes recorded by the social service worker, if the patient is receiving social services.
  - 2. Progress notes recorded and dated by the activity leader at least quarterly.
  - 3. Observation and information pertinent to the patient's diet recorded in the patient's UHR by the dietitian, nurse, or food service supervisor.

4. 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.
  5. Records of each treatment given by a therapist, weekly progress notes, and a record of reports to the physician after the first 2 weeks of therapy, and at least every 30 days thereafter.
  6. Vital sign record sheet to include temperature, pulse, respiration and blood pressure notations when indicated. [CDC Form 7304, 7211]
  7. Consent forms for prescribed treatment and medication not included in the Conditions of Admission/Placement. [CDC Form 7293]
  8. Records of all laboratory tests ordered, 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.
  9. Reports of all cardiographic or encephalographic tests performed.
  10. Reports of all radiologic examinations ordered.
  11. All reports of special studies ordered.
  12. Discharge planning notes, when applicable.
  13. Condition and diagnoses of the patient at the time of discharge or final disposition.
  14. A copy of the transfer form when the patient is transferred to another health facility.
  15. Discharge or transfer information and continuing care instructions.
- J. All health documentation received from transferring health facilities.