

CHAPTER 30

Content of Unit Health Record (UHR): Hospice

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 in the hospice setting 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 medical and spiritual care of the patient. It also protects the legal interests of the patient, the health facility, and provider.

The patient's UHR shall be current, concise, accurate, and kept in detail consistent with good medical and professional practice based on the service provided to each patient. The UHR shall be maintained in accordance with these requirements and shall be available for review by the Department. 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 hospice services shall consist of at least the following:

- A. Admission record with identification data including, but not limited to, the following using CDC Form 7201:
 1. Name
 2. Patient identification number
 3. Institution address
 4. Date of birth
 5. Sex
 6. Marital status
 7. Religion (optional on part of the patient)
 8. Ethnic/cultural background
 9. Date of admission and source of referral
 10. Date of discharge from referring facility, if applicable
 11. Date of discharge from hospice
 12. Name, address and telephone number of person to notify in case of emergency or death
 13. Name of attending physician
 14. Admission and subsequent diagnosis(es) and known allergies
 15. Discharge or final diagnosis(es)
- B. Clear and noticeable documentation of allergies and known untoward reactions to drugs and food.

- C. Plan of Care to include initial assessment and examination, and plan of care documented by the clinician.
- D. Current diagnoses and conditions with notations of those relevant to the Plan of Care.
- E. Physician orders for admission, activity, medication, treatment, diet orders, other hospice services, and discharge, signed, dated, and timed, on each visit. [CDC Form 7221]
- F. Statement of goals prepared by the Multidisciplinary Team to include authorized signature in a timely manner.
- G. Dated, timed, and signed health care notes demonstrating implementation and evaluation of the Plan of Care, including, but not limited to, the following:
 - 1. Evidence of coordination of services through the Multidisciplinary Team.
 - 2. Nursing notes shall be signed and dated to include teaching or instructions to patients and caregivers and documentation of results of instructions.
 - 3. Medication records including name, dosage, and time of administration of medications, and treatment given. The route of administration and site of injections 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]
 - 4. The reasons for the use of and the response of the patient to PRN medication administered and justification for withholding scheduled medications.
 - 5. Documentation of oxygen administration.
 - 6. Documentation of spiritual and volunteer services when provided, to include an initial spiritual assessment.
 - 7. Progress notes recorded by the social service worker, if the patient is receiving social services.
 - 8. Progress notes using the S.O.A.P.E. format including the patient's response to medication and treatment rendered and observation(s) of the patient at the time of service by all members of treatment team providing services to the patient. [CDC Form 7230]
 - 9. Documentation of medical supplies and appliances or special devices needed.
 - 10. Vital sign record sheet to include temperature, pulse, respiration and blood pressure notations when indicated. [CDC Form 7304, 7211]
 - 11. Consent forms for prescribed treatment and medication not included in the Conditions of Admission/Placement. [CDC Form 7293]
 - 12. Records of all laboratory, radiology, special study reports, and any other ancillary reports 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.
 - 13. Discharge or transfer information and continue care instructions if other than by death shall include:
 - a. Summary of patients physical, mental, spiritual, and emotional status at the time of discharge.
 - b. Method of initiation of discharge, i.e., by physician, hospice, patient/family.
 - c. Date and reason for termination of services.

- d. Referrals made, if necessary.
- e. Documentation of notification of the services to patient, family and physician.
- 14. Discharge notes and summary of all hospice services if discharged by death shall include:
 - a. Date and location of death.
 - b. Extent to which treatment goals were obtained including pain and symptom management.
 - c. Establishment of bereavement services plan.
- 15. Condition and diagnoses of the patient at the time of discharge or final disposition.
- H. All health documentation received from transferring health facilities.