

CHAPTER 31

Content of Unit Health Record (UHR): Outpatient Housing Unit

I. POLICY

The UHR must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the results accurately. The UHR in the outpatient housing unit setting serves as a basis for planning patient care and for continuity in the evaluation of the patient's condition. The content of the outpatient housing unit record must adequately document communication between providers responsible for the care of the patient, and any other health professional contributing to that care.

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 inmates receiving services in the outpatient housing unit shall consist of at least the following:

A. Identification data including, but not limited to, the following:

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 placement.
8. Date of release.
9. Name, address and telephone number of person or agency responsible for the inmate.
10. Initial diagnostic impression.
11. Discharge or final diagnosis.

B. Mental Status.

C. Preplacement evaluation or emergency room report (if applicable), which includes arrival information, chief complaint, objective findings, diagnosis, treatment, outcome, and disposition.

D. Physician placement medical history and physical within 24 hours of placement. 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 physician placement, and recorded in millimeters of

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induration in the medical history. The physician shall dictate, or may use CDC Form 7206 for a handwritten history and physical examination report. A history and physical completed within 5 days prior to physician placement may be used provided any clinical changes are noted.

- E. Dated, timed, and signed observations and progress notes using the S.O.A.P.E. format, including a working diagnosis, recorded at a minimum of every 14 days, or for any change in condition or treatment plan. There must be a progress note written for each clinician visit. CDC Form 7230
- F. Consultation reports, if applicable.
- G. Physician's orders for placement, activity, medication, treatment, testing, evaluation, consultation, diet, release, 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.
 - 2. Concise and accurate records of nursing care provided.
 - 3. Records of pertinent nursing observations of the patient and the patient's response to treatment.
 - 4. 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
 - 5. The reasons for the use of and the response of the patient to PRN medication administered and reason scheduled medications that were not administered. CDC Form 7230
 - 6. 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 Forms 7230, 7212, 7212B
 - 7. Record of restraint including: justification for application, note of time of application and removal, patient's status, and judgment of the physician or clinical psychologist on the necessity for continuation of clinical restraints at a minimum of once every twenty-four hours.
 - 8. Rehabilitation evaluation, if applicable.
 - 9. Interdisciplinary treatment plan, if applicable.
 - 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. CDC Form 7293
 - 13. All dental records, if applicable.
 - 14. Records of all laboratory tests ordered, initialed and dated by a CDC physician. Abnormal results shall be documented in the progress notes along with

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- documentation that the physician counseled the patient regarding abnormal result and treatment plan.
15. Reports of all cardiographic or encephalographic tests performed.
 16. Reports of all X-ray examinations ordered.
 17. All reports of special studies ordered.
 18. Labor and Delivery records, if applicable.
 19. A release summary prepared by the placement or primary care practitioner who shall recapitulate the significant findings and events of the patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care.
 20. Release or transfer information and continuing care instructions.
- K. All health documentation received from transferring health facilities.