

## **CHAPTER 35**

### **Content of Unit Health Record (UHR): Short Stay Inpatient**

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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 for short stay inpatients 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. A short stay is defined as less than 48 hours.

The patient's short stay health record 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 a short stay admission 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 visit.
8. Name of institution responsible for the inmate/patient treatment.
9. Name of attending physician.
10. Initial diagnostic impression.
11. Disposition at time of discharge.
12. Discharge or final diagnosis.

B. Emergency Room report (if applicable), which includes arrival information, chief complaint, objective findings, diagnosis, treatment, outcome, and disposition. [CDC Form 7286]

- C. Admission medical history and physical 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. The physician shall dictate, or may use the approved CDC Short Stay Form.
- D. Dated, timed, and signed observations and progress notes using the S.O.A.P.E. format, including a working diagnosis, as often as the patient's condition warrants by the person responsible for the care of the patient. There must be a progress note written for each clinician visit. [CDC 7230]
- E. Physician's orders for medication, activity, treatment, testing, evaluation, consultation, diet, discharge, or other services. [CDC Form 7221]
- F. Dated, timed, and signed health care notes including, but not limited to, the following:
  - 1. Concise and accurate records of nursing care provided. [CDC Form 7212]
  - 2. Records of pertinent nursing observations of the patient and the patient's response to treatment.
  - 3. 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]
  - 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. Vital signs. [CDC Form 7304, 7211]
  - 6. 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]
  - 7. Records of all ancillary tests ordered, initialed and dated by a CDC physician (to included lab, radiology, EKG, etc.). Abnormal results shall be documented in the progress notes along with documentation that the physician counseled the patient regarding abnormal result and treatment plan.
  - 8. All reports of special studies ordered.
  - 9. Labor records, if applicable.
  - 10. Discharge or transfer note and continuing care instructions.