A-1624

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§482.61(a)(3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

Interpretive Guidelines §482.61(a)(3)

The purpose of this regulation is to provide an understanding of what caused the patient to come to the hospital, and the patient's response to admission.

The hospital records the statements and reason for admission given by family and by others, as well as the patient (preferably verbatim), with informant identified, in a variety of locations, e.g., in transfer and admission notes from the physician, nurses and social workers.

Records should not contain vague, ill-defined reports from unknown sources. Records should record "who," "what," "where," "when," and "why."

Survey Procedures §482.61(a)(3)

Can the patient describe problems, stresses, situations experienced prior to hospitalization or do they still exist?
Who is the informant?
Did the informant witness the patient's behavior? If not, on what basis has the informant come to know the patient's behavior?
Has staff elicited whether the patient has exhibited similar behavior previously? If so, what was different this time to make hospitalization necessary?
Were there other changes/events in the patient's environment (death, separations of significant others) which contributed to the need for hospitalization? If so, has staff explored how these will impact in the patient's treatment? Has this been addressed by the treatment team?
Has there been an interruption or change in the patient's medication which may have been a factor in the patient's hospitalization?