72547 Content of Health Records

(a)

A facility shall maintain for each patient a health record which shall include: (1) Admission record. (2) Current report of physical examination, and evidence of tuberculosis screening. (3) Current diagnoses. (4) The orders of a licensed health care practitioner acting within the scope of his or her professional licensure, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. The orders of a licensed health care practitioner acting within the scope of his or her professional licensure shall be correctly recapitulated. (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include: (A) Records made by nurse assistants, after proper instruction, which shall include:1. Care and treatment of the patient. 2. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health. 3. Notification to the licensed nurse of changes in the patient's condition. (B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, 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. (C) Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person

administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials. (D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications. (E) Record of type of restraint and 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. (F) Medications and treatments administered and recorded as prescribed. (G) Documentation of oxygen administration. (6) Temperature, pulse, respiration and blood pressure notations when indicated. (7) Laboratory reports of all tests prescribed and completed. (8) Reports of all X-rays prescribed and completed. (9) Progress notes written and dated by the activity leader at least quarterly. (10) Discharge planning notes when applicable. (11) Observation and information pertinent to the patient's diet recorded in the patient's health record by the dietitian, nurse or food service supervisor. (12) Records of each treatment given by the therapist, weekly progress notes and a record of reports to the licensed health care practitioner acting within the scope of his or her professional licensure after the first two weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services. (13) Consent forms for prescribed treatment and medication not included in the admission consent for care. (14) Condition and diagnoses of the patient at time of discharge or final disposition. (15) A copy of the transfer form when the patient is transferred to another health facility. (16) An inventory of all patients' personal effects and valuables as defined in Section 72545(a) (12) made upon admission and discharge. The inventory list shall be

signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each. (17) The name, complete address and telephone number where the patient was transferred upon discharge from the facility.

(1)

Admission record.

(2)

Current report of physical examination, and evidence of tuberculosis screening.

(3)

Current diagnoses.

(4)

The orders of a licensed health care practitioner acting within the scope of his or her professional licensure, including drugs, treatment and diet orders, progress notes, signed and dated on each visit. The orders of a licensed health care practitioner acting within the scope of his or her professional licensure shall be correctly recapitulated.

(5)

Nurses' notes which shall be signed and dated. Nurses' notes shall include: (A) Records made by nurse assistants, after proper instruction, which shall include:1. Care and treatment of the patient. 2. Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health. 3. Notification to the licensed nurse of changes in the patient's condition. (B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, 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. (C) Name, dosage and time of administration of drugs, the route of

administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials. (D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications. (E) Record of type of restraint and 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. (F) Medications and treatments administered and recorded as prescribed. (G) Documentation of oxygen administration.

(A)

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1.

Care and treatment of the patient.

2.

Narrative notes of observation of how the patient looks, feels, eats, drinks, reacts, interacts and the degree of dependency and motivation toward improved health.

3.

Notification to the licensed nurse of changes in the patient's condition.

(B)

Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, 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.

(C)

Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.

(D)

Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.

(E)

Record of type of restraint and 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.

(F)

Medications and treatments administered and recorded as prescribed.

(G)

Documentation of oxygen administration.

(6)

Temperature, pulse, respiration and blood pressure notations when indicated.

(7)

Laboratory reports of all tests prescribed and completed.

(8)

Reports of all X-rays prescribed and completed.

(9)

Progress notes written and dated by the activity leader at least quarterly.

(10)

Discharge planning notes when applicable.

(11)

Observation and information pertinent to the patient's diet recorded in the patient's health record by the dietitian, nurse or food service supervisor.

(12)

Records of each treatment given by the therapist, weekly progress notes and a record of reports to the licensed health care practitioner acting within the scope of his or her professional licensure after the first two weeks of therapy and at least every 30 days thereafter. Progress notes written by the social service worker if the patient is receiving social services.

(13)

Consent forms for prescribed treatment and medication not included in the admission consent for care.

(14)

Condition and diagnoses of the patient at time of discharge or final disposition.

(15)

A copy of the transfer form when the patient is transferred to another health facility.

(16)

An inventory of all patients' personal effects and valuables as defined in Section 72545(a) (12) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

(17)

The name, complete address and telephone number where the patient was transferred upon discharge from the facility.