79805 Inmate-Patient Health Record Content

(a)

Each inmate-patient's health record for inpatient services shall consist of at least the following: (1) Admission and discharge record identification data including, but not limited to, the following: (A) Name. (B) Inmate-patient identification number. (C) Date of Birth. (D) Sex. (E) Marital status. (F) Religion (optional on part of inmate-patient). (G) Date of admission. (H) Date of discharge. (I) Name, address and telephone number of person or agency responsible for the inmate-patient, or next of kin. (J) Initial diagnostic impression. (K) Discharge or final diagnosis. (2) Mental status. (3) Admission medical history and physical within 24 hours of admission. This shall include written documentation of a test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA) within the past year, unless a previously positive result can be documented or completion of adequate preventive therapy or adequate therapy for active disease can be documented. If no written documentation is available, a tuberculosis test shall be administered within 24 hours of admission, and the result recorded in the medical history. The result of the tuberculosis test shall be reported as recommended in current guidelines of the Centers for Disease Control and Prevention regarding tuberculosis testing. (4) Dated and signed observations and progress notes recorded as often as the inmate-patient's condition warrants by

the person responsible for the care of the inmate-patient. (5) Consultation reports. (6) Medication, treatment and diet orders. (7) Social service evaluation, if applicable. (8) Psychological evaluation, if applicable. (9) Dated and signed health care notes including, but not limited to, the following: (A) Patient care plan. (B) Concise and accurate records of nursing care provided. (C) Records of pertinent nursing observations of the inmate-patient and the inmate-patient's response to treatment. (D) The reasons for the use of and the response of the inmate-patient to PRN medication administered and justification for withholding scheduled medications. (E) Record of type of restraint, including time of application and removal. (F) Rehabilitation evaluation, if applicable. (G) Interdisciplinary treatment plan, if applicable. (H) Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient. (I) Medication records including name, dosage, and time of administration of medications, and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration. (J) Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided. (K) Vital sign record sheet. (L) Consent forms as required, signed by the inmate-patient or the appropriate surrogate decision maker. (M) All dental records, if applicable. (N) Records of all laboratory tests ordered. (O) Reports of all cardiographic or encephalographic tests performed. (P) Reports of all X-ray examinations ordered. (Q) All reports of special studies ordered. (R) A discharge summary prepared by the admitting or primary care practitioner which shall recapitulate the significant findings and events of the inmate patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care. (S) Discharge or transfer

information and continue care instructions.

(1)

Admission and discharge record identification data including, but not limited to, the following: (A) Name. (B) Inmate-patient identification number. (C) Date of Birth. (D) Sex. (E) Marital status. (F) Religion (optional on part of inmate-patient). (G) Date of admission. (H) Date of discharge. (I) Name, address and telephone number of person or agency responsible for the inmate-patient, or next of kin. (J) Initial diagnostic impression. (K) Discharge or final diagnosis.

(A)

Name.

(B)

Inmate-patient identification number.

(C)

Date of Birth.

(D)

Sex.

(E)

Marital status.

(F)

Religion (optional on part of inmate-patient).

(G)

Date of admission.

(H)

Date of discharge.

(I)

Name, address and telephone number of person or agency responsible for the

inmate-patient, or next of kin.

(J)

Initial diagnostic impression.

(K)

Discharge or final diagnosis.

(2)

Mental status.

(3)

Admission medical history and physical within 24 hours of admission. This shall include written documentation of a test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA) within the past year, unless a previously positive result can be documented or completion of adequate preventive therapy or adequate therapy for active disease can be documented. If no written documentation is available, a tuberculosis test shall be administered within 24 hours of admission, and the result recorded in the medical history. The result of the tuberculosis test shall be reported as recommended in current guidelines of the Centers for Disease Control and Prevention regarding tuberculosis testing.

(4)

Dated and signed observations and progress notes recorded as often as the inmate-patient's condition warrants by the person responsible for the care of the inmate-patient.

(5)

Consultation reports.

(6)

Medication, treatment and diet orders.

(7)

Social service evaluation, if applicable.

(8)

Psychological evaluation, if applicable.

(9)

Dated and signed health care notes including, but not limited to, the following: (A) Patient care plan. (B) Concise and accurate records of nursing care provided. (C) Records of pertinent nursing observations of the inmate-patient and the inmate-patient's response to treatment. (D) The reasons for the use of and the response of the inmate-patient to PRN medication administered and justification for withholding scheduled medications. (E) Record of type of restraint, including time of application and removal. (F) Rehabilitation evaluation, if applicable. (G) Interdisciplinary treatment plan, if applicable. (H) Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient. (I) Medication records including name, dosage, and time of administration of medications, and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration. (J) Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided. (K) Vital sign record sheet. (L) Consent forms as required, signed by the inmate-patient or the appropriate surrogate decision maker. (M) All dental records, if applicable. (N) Records of all laboratory tests ordered. (O) Reports of all cardiographic or encephalographic tests performed. (P) Reports of all X-ray examinations ordered. (Q) All reports of special studies ordered. (R) A discharge summary prepared by the admitting or primary care practitioner which shall recapitulate the significant findings and events of the inmate patient's treatment, his/her condition on discharge and the

recommendation and arrangements for future care. (S) Discharge or transfer information and continue care instructions.

(A)

Patient care plan.

(B)

Concise and accurate records of nursing care provided.

(C)

Records of pertinent nursing observations of the inmate-patient and the inmate-patient's response to treatment.

(D)

The reasons for the use of and the response of the inmate-patient to PRN medication administered and justification for withholding scheduled medications.

(E)

Record of type of restraint, including time of application and removal.

(F)

Rehabilitation evaluation, if applicable.

(G)

Interdisciplinary treatment plan, if applicable.

(H)

Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient.

(I)

Medication records including name, dosage, and time of administration of medications, and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration.

(J)

Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided.

(K)

Vital sign record sheet.

(L)

Consent forms as required, signed by the inmate-patient or the appropriate surrogate decision maker.

(M)

All dental records, if applicable.

(N)

Records of all laboratory tests ordered.

(O)

Reports of all cardiographic or encephalographic tests performed.

(P)

Reports of all X-ray examinations ordered.

(Q)

All reports of special studies ordered.

(R)

A discharge summary prepared by the admitting or primary care practitioner which shall recapitulate the significant findings and events of the inmate patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care.

(S)

Discharge or transfer information and continue care instructions.