CHAPTER **8**

c0008

The Patient's Electronic Medical Record or Chart

OUTLINE

CHAPTER OBJECTIVES

p0010 *On completion of this chapter, you will be able to:*

o0010 1. Define the terms in the vocabulary list.
o0015 2. Write the meaning of the abbreviations in the abbreviations list.
o0020 3. List six purposes for maintaining an electronic medical record (EMR) or paper chart for each patient.
o0025 4. Demonstrate knowledge of military time by converting military time to standard time and standard time to military time.
o0030 5. List five guidelines to be followed by all personnel when entering information into a patient's EMR.
o0035 6. Describe how the patient's medical records are organized and identified when paper charts are used, and list five guidelines to be followed by all personnel when writing on a patient's paper chart.

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o0040 7. Identify four standard patient chart forms that are initiated in the admitting department.
o0045 8. State the purpose of seven standard chart forms included in a patient's electronic or paper admission packet, and list information that is included on the history and physical form.
o0050 9. Define what is meant by a *supplemental chart form*, and provide at least two examples of supplemental chart forms.
o0055 10. Explain the importance of accurately charting vital signs in a timely manner, and explain the correction of three types of errors on a graphic record.
o0060 11. Describe the purpose of a consent form, and list five guidelines to follow in the preparation of a consent form.
o0065 12. List four types of permits or release forms that patients may be required to sign during a hospital stay.
o0070 13. Describe the methods for correcting a labeling error and a written entry error on a patient's paper chart form.
o0075 14. List seven health unit coordinator (HUC) duties in monitoring and maintaining the patient's EMR.
o0080 15. List eight HUC duties in maintaining a patient's paper chart.
o0085 16. Explain the purpose and process of splitting or thinning a patient's chart, stuffing charts, and reproducing chart forms.

VOCABULARY

p0095 **Admission Packet** A preassembled packet of standard chart forms to be used on admission of a patient to the nursing unit.
p0100 **Allergy** An acquired, abnormal immune response to a substance that does not normally cause a reaction; such substances may include medications, food, tape, and many other items.
p0105 **Allergy Bracelet** A plastic bracelet (usually red) that is worn by a patient that indicates allergies he or she may have.
p0110 **Allergy Label** A label affixed to the front cover of a patient's paper chart that indicates the patient's allergy.
p0115 **Identification Labels** Labels that contain individual patient information for identifying patient records or other personal items.
p0120 **Name Alert** A method of alerting staff when two or more patients with the same or similarly spelled last names are located on a nursing unit.
p0125 **Old Record** A patient's paper record from previous admissions, stored in the health information management department, that may be retrieved for review when a patient is admitted to the emergency room, nursing unit, or outpatient department; older microfilmed records also may be requested by the patient's doctor.
p0130 **Split or Thin Chart** Portions of the patient's current paper chart are removed when the chart becomes so full that it is unmanageable.
p0135 **Standard Chart Forms** Forms included in all inpatient paper charts that are used to regularly enter information about patients.
p0140 **Stuffing Charts** Placing extra chart forms in patients' paper charts so they will be available when needed.
p0145 **Supplemental Chart Forms** Patient chart forms used only when specific conditions or events dictate their use.
p0150 **WALLaroo** A locked workstation that is located on the wall outside a patient's room; it stores the patient's paper chart or a laptop computer, and when unlocked it forms a shelf to write on.

ABBREVIATIONS

t0015
p0155 *Note:* These abbreviations are listed as they are commonly written; however, they also may be seen in uppercase or lowercase letters and with or without periods.

Abbreviation	Meaning
H&P	history and physical
Hx	history
ID labels	identification labels
MAR	medication administration record
NKA	no known allergies
NKFA	no known food allergies
NKMA	no known medication allergies
NKDA	no known drug allergies

EXERCISE 1

b0010
p0160 *Write the abbreviation for each term listed.*

1. history
2. no known allergies
3. identification labels
4. history and physical
5. medication administration record
6. no known medication allergies
7. no known drug allergies
8. no known food allergies

EXERCISE 2

b0015
p0210 *Write the meaning of each abbreviation listed.*

1. ID labels
2. NKFA
3. MAR
4. NKA
5. NKDA
6. H&P
7. Hx
8. NKMA

PURPOSES AND USE OF A PATIENT'S ELECTRONIC MEDICAL RECORD OR PAPER CHART

s0010
p0260 The patient's electronic medical record (EMR) or paper chart serves many purposes, but for a health unit coordinator (HUC), the electronic record or chart is seen mainly as a means of communication between the doctor and the hospital staff.

p0265 The EMR or chart is also used for planning patient care, for research, and for educational purposes. As a legal electronic record or documentation, the medical record protects the patient, the doctor, the staff, and the hospital or health care facility. Careful entries and notations by doctors and other personnel provide an electronic or written record of the patient's illness, care, treatment, and outcomes of hospitalization. If the patient is readmitted to the hospital or health care facility, the paper chart may be retrieved from the health information

management system (HIMS) department, also commonly called the *medical records department*. The advantage of the EMR is that all previous health information is immediately available on the computer.

HIGH PRIORITY

b0020 **Purposes of a Patient's Electronic Medical Record or Paper Chart**

- Means of communication
- Documentation and planning of patient care
- Research
- Education
- Legal record or documentation
- History of patient illnesses, care, treatment, and outcomes

s0015 The Patient Electronic Medical Record or Paper Chart as a Legal Document

p0305 When a patient is discharged, health information management personnel will analyze and check the EMR for completeness and will notify the appropriate nurses and/or doctors when they must go into the computer to complete the records. The patient's previous EMR will be available on computer to the patient's doctor, or if the patient is readmitted to the hospital. The Security Rule, a key part of the Health Insurance Portability and Accountability Act (HIPAA), protects a patient's electronically stored information (see Chapter 6).

p0310 The paper chart must be sent to HIMS as soon as possible. Health information management personnel will analyze and check the chart for completeness. When records are not complete or signatures are missing, those chart forms are flagged, and the appropriate nurses and/or doctors are notified that they must come to HIMS to complete or sign the chart forms.

p0315 Doctors and nurses must go to HIMS to see or complete old patient records if the patient has not been readmitted to the hospital. Completed paper charts are indexed and stored where they are available for retrieval as needed.

p0320 Older paper records are microfilmed (documents are placed on film in reduced scale) and stored. On request, health information management personnel may retrieve microfilmed records. The length of time that the record must be stored depends on the laws of the state. Unless a patient has been readmitted to the hospital, HIMS will not send an **old record** to nursing units.

p0325 The patient's electronic or paper medical record may be subpoenaed and may serve as evidence in a court of law. As a legal document, it must be maintained in an acceptable manner.

s0020 Military Time

p0330 Military time is a system that uses all 24 hours in a day (each hour has its own number) rather than repeating hours and using AM and PM. When military time is used, there are always four digits, the first two digits representing hours and the second two representing minutes. For example, 1:45 AM is recorded as 0145, and 1:45 PM is recorded as 1345; the colon is not needed when military time is used (Table 8-1). The hours after midnight are recorded as 0100, 0200, and so forth. Thirty minutes after midnight is written as 0030. Twelve noon is recorded as 1200, and the hours that follow are arrived at by adding the hours after noon to 1200. Thus 1:00 PM is 1200 + 100 = 1300, 2 PM is 1200 + 200 = 1400, and so forth. See Figure 8-1 for a comparison of standard and military times. Military time is used with the EMR and paper chart systems and eliminates confusion because hours are not repeated, and AM or PM is unnecessary.

TABLE 8-1 Standard and Military Time Comparisons t0010

Standard Time	Military Time	Standard Time	Military Time
12:15 AM	0015	1:00 PM	1300
12:30 AM	0030	1:15 PM	1315
12:45 AM	0045	1:30 PM	1330
1:00 AM	0100	1:45 PM	1345
2:00 AM	0200	2:00 PM	1400
3:00 AM	0300	3:00 PM	1500
4:00 AM	0400	4:00 PM	1600
5:00 AM	0500	5:00 PM	1700
6:00 AM	0600	6:00 PM	1800
7:00 AM	0700	7:00 PM	1900
8:00 AM	0800	8:00 PM	2000
9:00 AM	0900	9:00 PM	2100
10:00 AM	1000	10:00 PM	2200
11:00 AM	1100	11:00 PM	2300
12:00 Noon	1200	12:00 Midnight	2400

SKILLS CHALLENGE b0025

To practice converting standard time to military time, complete Activity 8-1 in the *Skills Practice Manual.*

Confidentiality s0025

p0340 As was discussed in Chapter 6, the EMR or paper chart is confidential, and the HUC is a custodian of all patient medical records (electronic or paper) on the unit. Any information provided by the patient to the health care facility and the medical staff is confidential. All health care personnel are required to have a code and a password to gain access to a patient's EMR. Portions of the patient's EMR may be available only to the patient's doctor and nurses.

HIGH PRIORITY

b0030 All access to a patient's electronic medical record (EMR) is monitored and recorded in the system. This serves to protect patient confidentiality and is a way to trace any errors or modifications made in the patient's EMR.

THE ELECTRONIC MEDICAL RECORD s0030

p0350 The patient's EMR may be accessed by health care personnel after entering a user ID and a password. Once logged in, the health care personnel are able to access and should access only the EMR of the patients in their specific nursing unit. Health care personnel choose the patient's name from the nursing unit census displayed on the screen; this will allow them to view

f0010

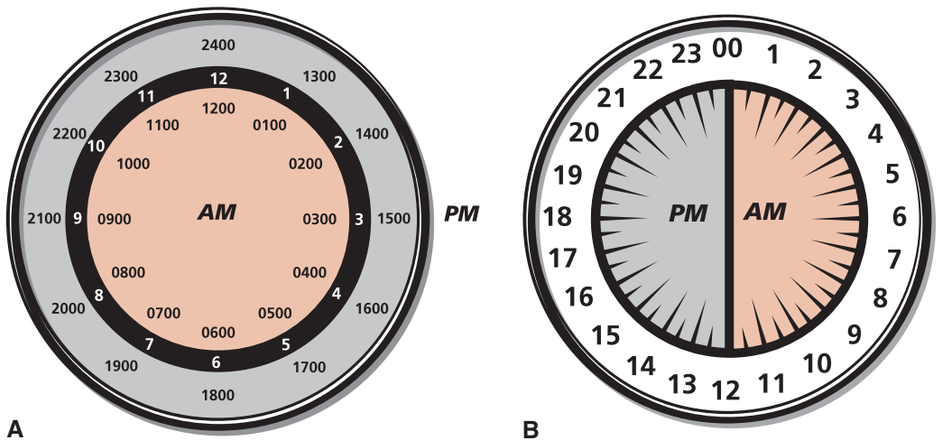


Figure 8-1 **A,** A 24-hour clock showing military time. **B,** Military time.

and enter information into the patient's EMR. An icon will be displayed next to a patient's name when there is a task or communication for the nurse or HUC written by the patient's doctor. A name alert flag may be placed on the patient's EMR when two or more patients with the same or similarly spelled names are located on the unit. If an order has been written stating that the patient's admission is not to be published, NINP (no information, no publication) is noted on the EMR or the patient may be listed as a "confidential patient."

s0035 **Guidelines to Follow When Entering Information into the Patient's Electronic Medical Record**

o0170 1. All entries into the EMR must be accurate.
o0175 2. Handwritten progress notes, electrocardiograms, consents, anesthesia records, and outside records and reports must be scanned into the EMR.
o0180 3. Errors made in care or treatment must be documented and cannot be falsified.
o0185 4. All entries into the EMR must include the date and time (military or standard) of the entry.
o0190 5. Abbreviations may be used in keeping with the health care facility's list of "approved abbreviations."

s0040 ## THE PAPER CHART

s0045 **Guidelines to Follow When Writing in a Patient's Paper Chart**

p0385 All persons who write in the paper chart follow standard guidelines. The HUC has minor charting tasks but is responsible for patient charts and so should be aware of the following basic rules:

o0195 1. All paper chart form entries must be made in ink. This is to ensure permanence of the record. Black ink is preferred by many health care facilities because it produces a clearer picture when the record is microfilmed, faxed, or reproduced on a copier.
o0200 2. Written entries on paper chart forms must be legible and accurate. Entries may be made in script or printed. Diagnostic reports, history and physical examination reports, and surgery reports are usually computer generated.
o0205 3. Recorded entries on the paper chart may not be obliterated or erased. The method for correcting errors is outlined later in this chapter.
o0210 4. All written entries on paper chart forms must include the date and time (military or standard) of the entry.
o0215 5. Abbreviations may be used in keeping with the health care facility's list of "approved abbreviations."

s0050 **The Chart Binder**

p0415 Forms that constitute the patient's paper chart are usually kept together in a three-ring binder. The binder may open from the bottom, or it may be a notebook that opens from the side, the top, or the bottom (Fig. 8-2).

p0420 The chart forms in the binder are sectioned off by dividers placed in the chart according to the sequence set forth by the health care facility (Fig. 8-3).

p0425 Paper charts are identified for each patient with a label that contains the patient's name and the doctor's name. The room and bed number may be written on the outside of the chart binder. Many health care facilities use colored tape on the outside of the chart to assist doctors in identifying their patients' charts. An **allergy label** is affixed to the chart binder if the patient has a medication, food, adhesive tape, or other type of allergy. Labels or tape affixed to chart binders are also used to alert the hospital staff of special situations. For example, a **name alert**, a piece of tape with *name alert* recorded on it, may be placed on the chart binder to remind staff that another patient with the same or a similarly spelled last name is housed on the unit. When an order indicates that a patient's admission is not to be published, *NINP* is often recorded on the chart binder to remind staff members that no information about a particular patient is to be issued.

s0055 **The Chart Rack for Paper Charts**

p0430 Many types of chart racks are available on the market. One type allows patient paper charts to be placed in a chart rack in which each slot on the rack holds one patient chart. Slots are labeled with the room and bed numbers; they usually are numbered in the same sequence as the rooms on the nursing unit (Fig. 8-4). Another type of chart storage is a **WALLaroo,** a locked

f0015

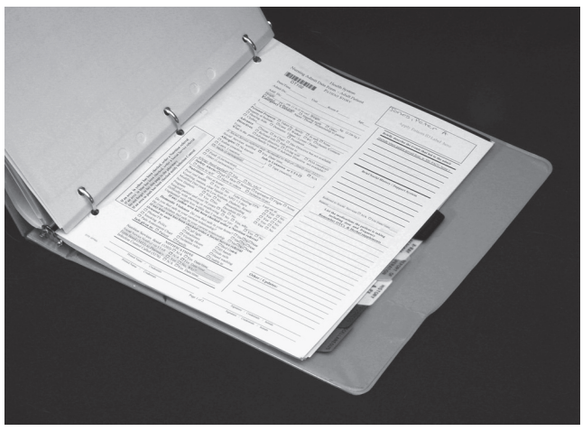


Figure 8-2 Patient's chart with dividers.

f0020

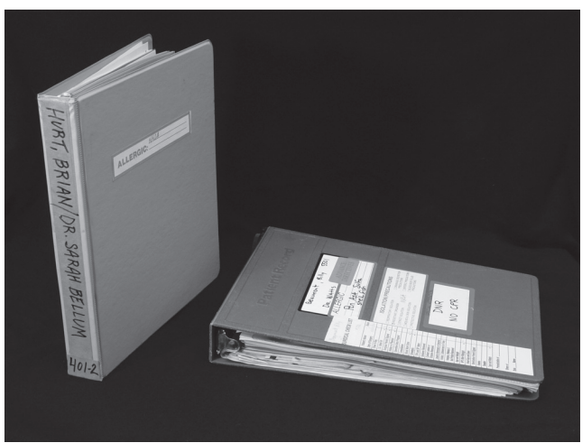


Figure 8-3 Patient chart binders properly labeled.

workstation that is located on the wall outside the patient's room. It stores a patient's paper chart or a laptop computer and when unlocked forms a shelf to write on (Fig. 8-5).

HIGH PRIORITY

b0035 Health care facilities that have implemented the electronic medical record are utilizing the WALLaroo located just outside the patient's room as a computer workstation.

s0060

PATIENT IDENTIFICATION LABELS

p0440 A packet of patient **identification labels** is printed from the computer when the patient is admitted and as needed during the hospital stay. Information on the identification labels usually includes the following: the patient's name, age, sex, account number, health record number, admission date, and attending physician's name; a bar code may be included for identification purposes (Fig. 8-6). When the EMR is implemented, identification labels are kept in a "label book"; and when paper charts are used, they are kept in each patient's chart. The identification labels are used on consents, specimens, clothing, and other belongings. Labels may be generated from the computer and printed on a label printer.

f0025

Figure 8-4 Chart rack.

STANDARD PATIENT CHART FORMS

s0065

Preparing the Patient's Paper Chart

s0070

p0445 Each health care facility has specific standard forms that are placed in all patients' paper charts. These forms are preassembled, clipped together (by the HUC or by volunteers), and filed in a drawer or on shelves near the HUC area. Some hospitals use computerized chart forms. These chart forms can be printed for individual patients with patient identification information printed on the forms. These assembled forms are often referred to as an **admission packet.**

p0450 On a patient admission, the HUC obtains an admission packet from the drawer or shelf and labels each form with the patient's identification (ID) label. If the forms are computerized, the HUC chooses the patient's name on the computer and prints the forms with the patient's identification information printed on them. Forms that need dates and days of the week are filled in and are then are placed behind the proper chart divider in a chart binder (Box 8-1, *Twelve Standard Chart Forms*).

HIGH PRIORITY

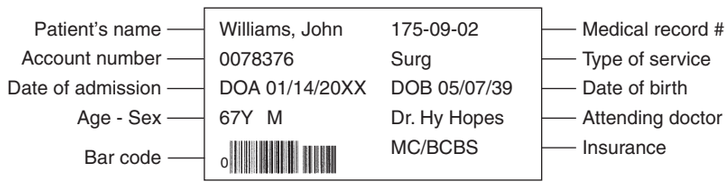
b0040 When the electronic medical record (EMR) is implemented, information details are directly entered or scanned into the patient's EMR. Patient identification labels are placed in a binder that contains labels and face sheets for all patients on that nursing unit.

SKILLS CHALLENGE

b0045 To practice preparing a patient's paper chart, complete Activity 8-2 in the *Skills Practice Manual.*

p0465 Standard patient chart forms are included in all inpatient paper charts and may vary in different hospitals. When the EMR is implemented, information is entered into the computer on similar electronic forms. The following **standard chart forms** are the most commonly used presently.

f0030 **Figure 8-5** A workstation with storage for the patient's paper chart is called a WALLaroo.



f0035 **Figure 8-6** Patient identification label.

BOX 8-1 TWELVE STANDARD CHART FORMS

b0085 **Initiated in the Admitting Department**

1. Face sheet or information form
2. Admission and service agreement form
3. Patients' rights
4. Advance directive checklist

Initiated by the Physician

5. History and physical form (H&P)

Included in the Admission Packet

6. Physician's order form
7. Physician's progress record
8. Nurse's admission record
9. Nurse's progress notes or flow sheets
10. Medication administration record (MAR)
11. Nurse's discharge planning form
12. Physician's discharge summary

s0075 ## Standard Patient Chart Forms Initiated in the Admitting Department

s0080 ### *1. Face Sheet or Information Form*

p0470 The face sheet or information form (Fig. 8-7) contains information about the patient, such as name, address, telephone number, name of employer, admission diagnosis, health care insurance policy information, and next of kin. In most health care facilities, the form originates in the admitting department and is then sent to the unit to be placed in the patient's chart. When the EMR is implemented, the information is entered directly into the patient's EMR. Several face sheets (at least five) are kept in the binder containing patient labels when EMR is used and in each patient's chart when paper charts are used. Face sheets are taken by the attending physician and by consulting physicians to be used for billing purposes. The HUC can generate copies of the face sheet on the computer. The face sheet is also used on the nursing unit to locate information when staff must call the family or call consulting physicians.

s0085 ### *2. Admission and Service Agreement Form (may also be called* Conditions of Admission *[COA])*

p0475 The admission and service agreement form (Fig. 8-8) is signed by the patient in the admitting department and is then sent to the admitting unit to be scanned into the patient's EMR or placed in the patient's paper chart. The form provides legal permission to the hospital and doctor to treat the patient and also serves as a financial agreement.

s0090 ### *3. Patients' Rights*

p0480 The Joint Commission requires that all hospitals have a bill of rights and a notice of the facility's privacy practices. Copies must be given to each patient or legal guardian of the patient on admission. In addition, a copy of the bill of rights should be posted at entrances and other prominent places throughout the hospital. The patients' bill of rights varies in wording among hospitals, but all are based on the basic ethical principles outlined in Chapter 6.

Opportunity Medical Center

Account #	Admit Date	Admit Time	Reg Init	Brought By	Info Provided By	MR Number
01149408	01/14/XX	1430	EG	Wife	Patient	30897811

Admitting Physician	Primary Care Phys.	Room #	Type	Service	Discharge Date	Discharge Time
John Bauer	John Bauer	406		Surg		

Patient Last Name First Middle	Former Name	Race	Rel Pref	Social Security #
Williams, John		C	do not	111-11-1111

Patient Address	Apt. No.	City	State	Zip Code	Patient Phone #
294 W Filmore St		Sinclaire	NJ	90376-9009	222-222-2222

Driver's License #	Age	Birth Date	Birthplace	Gender	MS	Occupation	Accident? Date/Time
N/A	67	05/07/39	Ohio	M	M	Teacher	N/A

Patient Employer	Employer Address	Employer Phone
Retired May 2005		

Spouse Name	Spouse Address	City	State	Spouse Phone
Elaine Ann	9030 W. 3 Ave	Peoria	Ohio	200-330-3333

Emergency Contact	Relationship	Home Phone	Cell Phone	Work Phone
Jean Sounders	daughter	102-202-2002	N/A	102-101-1001

Admitting Diagnosis	Admit Type	ICD9	Admit Source
MVA - diabetes	Surg		Clinic

Primary Insurance Plan	Primary Policy #	Authorization #	Primary Policy Holder
Medicare	111-11-1111A		

Insurance Plan #2	Secondary Policy #	Authorization #	Secondary Policy Holder
Pacific Care	22020111		

Insurance Plan #3	Tertiary Policy #	Authorization #	Tertiary Policy Holder

Guarantor Name	Rel to Pt	Mailing Address	Guarantor Phone

Guarantor Occupation	Employer	Employer Address	Employer Phone

Billing Remarks:

Principal Diagnosis: MVA Code: 050

Secondary Diagnosis: Diabetes Code: 268

Operations and Procedures:	Physician	Date	Code

Consulting Physician:

Final Disposition: ◯ Discharged ◯ Transferred ◯ Left AMA ◯ Expired ◯ Autopsy ◯ Yes ◯ No

I certify that my identification of the principal and secondary diagnosis and the procedures performed is accurate to the best of my knowledge.

Opportunity Medical Center

Attending Physician Date

f0040

Figure 8-7 Face sheet or information form. (Copyright 2004, Elsevier Inc. All Rights Reserved.)

Williams, John	175-09-02
0078376	Surg
DOA 01/14/20XX	DOB 05/07/39
67Y M	Dr. Hy Hopes
0	MC/BCBS

MEDICAL TREATMENT AGREEMENT
(Conditions of Admission)

Patient or the patient's legal representative agrees to the following terms of hospital admission:

1. **MEDICAL TREATMENT :**
   The patient consents to the treatment, services and procedures which may be performed during this hospitalization or on an outpatient basis, which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatments or procedures, anesthesia, or hospital services rendered under the general or specific instructions of the responsible physicians or other health care providers. The hospital may establish certain criteria which will automatically trigger the performance of specific tests which the patient agrees may be performed without any further separate consent. This Medical Treatment Agreement covers E-ICU services and outpatient services provided by the hospital's extended treatment facilities, including services at other Banner facilities. Where the hospital routinely provides services for inpatients at an outpatient facility in close proximity to the hospital, the patient consents to transport to the outpatient facility for the requested services. This Medical Treatment Agreement is effective for this inpatient admission/outpatient visit and/or for recurring outpatient services of the same type for a period of one year following its execution. For obstetrical patients this Medical Treatment Agreement covers both outpatient and inpatient services and also covers and applies to both the obstetrical patient and the newborn(s). Photographs or videotapes may be made of diagnostic and surgical procedures for treatment and/or training purposes.
2. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND HEALTH CARE PROVIDERS:**
   The patients will be treated by his/her attending physician or health care providers and be under his/her care and supervision. Physicians and other health care providers furnishing services to the patient, including but not limited to the emergency room physician, hospitalist, radiologist, pathologist, and anesthesiologist, are generally not employees or agents of the hospital. These providers may bill separately for their services. Questions about whether a health care provider is an agent or employee of the hospital should be directed to Administration during normal business hours, and the Administrator On Call or the Chief Nursing Officer/Designee after hours, weekends, and holidays.
3. **MONEY AND VALUABLES:**
   VALUABLES AND MONEY SHOULD BE RETURNED TO YOUR RESIDENCE. The hospital has a safe in which to keep money or valuables. The hospital will not be responsible for loss of or damage to items not deposited in the safe (such as glasses, dentures, hearing aids, contact lenses, jewelry or money).
4. **TEACHING PROGRAM:**
   The hospital participates in training programs for physicians and heath care personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or hospital employees. These persons in training may also observe care given to the patient by physicians and hospital employees.
5. **RELEASE OF INFORMATION:**
   The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED INFORMATION) may be released to the following.

A. Health care providers who are providing or have provided health care to the patient or their agents; any individual or entity responsible for the payment of hospital's or other provider's charges; to health care providers or organizations accrediting the facility or conducting utilization reveiw, quality assurance, or peer review; and to the hospital's and provider's legal representatives and professional liability carriers.
B. Individuals and organizations engaged in medical education and research, provided that information may only be released for use in medical studies and research without patient identifying information.
C. Individuals and entities as specified by federal and state law and/or in the hospital's Notice of Privacy Practices.
D. Patient records of services provided at any Banner facility or Banner Surgicenter may be exchanged among these facilities where necessary to provide appropriate patient care. This Release shall continue for so long as the medical and/or financial records are needed for any of the above-stated purposes.

6. **CONTRABAND:**
   Drugs, alcochol, weapons and other articles specified as contraband by the hospital may not be brought onto hospital premises. Any illegal substance will be confiscated and turned over to law enforcement authorities. If the presence of contraband is suspected, the patient's room and belongings may be searched, and visitors may be searched before visitation.

ACKNOWLEDGEMENTS

☐ I acknowledge receipt of the hospital's "Patient Rights and Responsibilities" brochure.
☐ I acknowledge receipt of the hospital's "Notice of Privacy Practices".
☐ I acknowledge receipt of either the "Important Message from Medicare'' or the "Important from Tricare'' (if applicable).

I have read and understand this Medical Treatment Agreement, have received a copy of this agreement, the hospital's "Notice of Privacy Practices,'' the hospital's "Patient Rights and Responsibilities'' brochure, and where applicable the "Important Message from Medicare/Tricare.'' I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

Patient/Parent of Minor Child/Court-Appointed Guardian
Patient-Appointed Agent/Statutory Surrogate
Please circle the correct title

Witness

Date: Time:

f0045 **WHITE** - Chart Copy, **CANARY** - Patient Services Copy, **PINK** - Patient Copy

Figure 8-8 Admission and service agreement.

Continued

Williams, John	175-09-02
0078376	Surg
DOA 01/14/20XX	DOB 05/07/39
67Y M	Dr. Hy Hopes
0	MC/BCBS

MEDICAL TREATMENT AGREEMENT (Conditions of Admission)

HEALTH CARE DIRECTIVES

If you have a Health Care Power of Attorney and/or Living Will you should provide it to the hospital to best assure that the hospital is aware of your wishes and that they are followed if you become unable to make or communicate your own health care decisions. If you do not have a Living Will or Health Care Power of Attorney and wish to have one, we can provide information and assistance.

I have completed a Health Care Power of Attorney

If Yes:
- ☐ Power of Attorney presented to hospital
- ☐ Power of Attorney requested from family

If No:
- ☐ "Making Decisions About Your Health Care" brochure provided
- ☐ Power of Attorney form provided
- ☐ Information declined

I have completed a Living Will

If Yes:
- ☐ Living Will presented to hospital
- ☐ Living Will requested from family

If No:
- ☐ "Making Decisions About Your Health Care" brochure provided
- ☐ Living Will form provided
- ☐ Information declined

Health Care Power of Attorney

To be completed by the **patient** only when a Health Care Power of Attorney has not been provided to the hospital.

Health Care Power of Attorney A.R.S. § 36-3224: I, as principal, designate:

_____
Name

_____
Address

_____
Phone

as my agent to act in all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This Health Care Power of Attorney is effective upon my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions, or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent, and acting for myself. This health care directive is authorized under A.R.S. § 36-3221 and continues in effect including for subsequent admissions, for all who may rely upon it except to those to whom I have given notice of its revocation.

_____ _____
Patient Date Time

I was present when the patient signed and dated this Health Care Power of Attorney. The Patient appears to be of sound mind and free from duress at the time he/she executed this Power of Attorney.

_____
*Witness

(*The witness may **not** be related to the patient by blood, marriage, or adoption; may **not** be the agent appointed as the Health Care Power of Attorney; may **not** be entitled to any portion of the patient's estate; and may **not** be directly involved in the patient's care.)

☐ **Unable to complete due to the need for immediate medical attention**

Additional attempts to complete

Date: _____ Time: _____ Initials: _____ Reasons: _____

Date: _____ Time: _____ Initials: _____ Reasons: _____

Date: _____ Time: _____ Initials: _____ Reasons: _____

WHITE - Chart Copy, **CANARY** - Patient Services Copy, **PINK** - Patient Copy

Figure 8-8, cont'd

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FINANCIAL AGREEMENT

I agree that, in return for the services provided to the patient by the hospital or other health care providers, I will pay the account of the patient or make financial arrangements for payment prior to discharge satisfactory to the hospital and all other providers. I will pay the hospital's charges as set out in the hospital's chargemaster, which are the rates currently on file with the Arizona Department of Health Services. I understand that the chargemaster is available for inspection upon request. I understand that the rates charged for services rendered to the patient may differ from the amounts other patients are obligated to pay based upon each patient's private insurance coverage, Medicare/AHCCCS coverage, or lack of any such coverage. A delinquent account will be subject to interest at the legal rate of 10% per annum.

I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

If any signer (or the patient) is entitled to benefits of any type whatsoever, under any policy of health of liability insurance insuring patient, or any other party liable to patient, that benefit is hereby assigned to hospital and/or to the provider group rendering service, for application on patient's bill. HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL.

IN GRANTING ADMISSION OR RENDERING TREATMENT, THE HOSPITAL AND OTHER PROVIDERS ARE RELYING ON MY AGREEMENT TO PAY THE ACCOUNT. EMERGENCY CARE WILL BE PROVIDED WITHOUT REGARD TO THE ABILITY TO PAY.

X _____ _____

Patient or Other Party Agreeing to Pay | Relationship to Patient

_____ _____

Witness | Date & Time

WHITE-Medical Record Copy • **CANARY**-Patient Services Copy • **PINK**-Patient Copy

Figure 8-8, cont'd

s0095 ***4. Advance Directive Checklist Form***

p0485 An advance directive checklist form (Fig. 8-9) documents that a patient has been informed of his or her choice to declare health care decisions. Advance directives are discussed in Chapter 19. The Patient Self Determination Act of 1990 mandates that all patients admitted to a health care facility must be asked whether they have or wish to have an advance directive. The patient or guardian signs the advance directive checklist, then it is sent to the admitting unit to be scanned into the patient's EMR or placed in the patient's paper chart to document that the patient was advised of his or her choices. When the EMR is being used, the advance directive form may be converted into an electronic version.

s0100 **Standard Patient Chart Forms Included in the Admission Packet**

s0105 ***1. Physician's Order Form***

p0490 The physician's order form or doctor's order sheet is the form on which the doctor requests care and treatment procedures for the patient (see Chapter 9, the *Skills Practice Manual*, and the Evolve website for examples of orders). All orders must be dated and signed by the physician writing the order. When the EMR is implemented, the physician enters orders directly into the computer, and the orders are routed to the appropriate departments, including the pharmacy. When paper charts are used, the physician's order form may be available in a single-page format (in which case the HUC will fax or scan and send a copy to the pharmacy) or in duplicate format (in which case the HUC will send the copy of the original physician's order [commonly called the *pharmacy copy*] to order the patient's medications). It is essential that the pharmacist see the original physician's orders to eliminate errors in the transcription process. A copy may also be created on a fax machine and given to the appropriate nursing personnel.

s0110 ***2. Physician's Progress Record***

p0495 The progress record is a form on which the physician records the patient's progress during the patient's hospitalization. Medical staff rules and regulations and the patient's condition

ADVANCE DIRECTIVE CHECKLIST

Patient Name: _____

❑ Advance Directives Brochure Provided ❑ Advance Directives Brochure Refused

The Following Information Was Obtained From: ❑ Patient ❑ Other: _____

❑ **Patient HAS executed the following Advance Directive(s):**	COPY RECEIVED THIS ADMIT	COPY RECEIVED PRIOR ADMIT	COPY REQUESTED
❑ Declaration for Health Care Decisions (Living Will)	❑	❑	❑
❑ Medical Power of Attorney (MPOA)	❑	❑	❑
Name: _____			
Relationship: _____			
❑ Mental Healthcare Power of Attorney (MHPOA)	❑	❑	❑
Name: _____			
Relationship: _____			
❑ Combination Power of Attorney (that includes MPOA language)	❑	❑	❑
❑ Other: (specify)	❑	❑	❑

❑ Patient **HAS NOT** executed Advance Directive(s). (Check items below **ONLY** when talking with patient.)	**PATIENT Was Advised On** _____ (date).
❑ **PATIENT** requests more information.	❑ of the *right to accept or refuse medical treatment.*
❑ Social Services notified.	❑ of the *right to formulate Advance Directives.*
❑ **PATIENT** chooses not to execute Advance Directives at this time.	❑ of the *right to receive medical treatment whether or not there is an Advance Directive.*

For Home Health/Hospice Use Only:

❑ Patient **HAS** EXECUTED Prehospital Medical Care (Arizona's Orange Card).

❑ Patient was advised of the *right to have Advance Directives followed by the health care facility and caregivers to the extent permitted by law.*

Signature of Facility Representative:	Department:	Date:

IF ADVANCED DIRECTIVE IS UNAVAILABLE, *the patient indicates that the substance of the directive is as follows: (see reverse for script)*

Living Will: _____

Medical Power of Attorney: _____

❑ Patient signature (legal representative if applicable): _____

❑ Witness signature (if patient physically unable to sign): _____ Reason: _____

Verification Upon Admit/Re-Admit or Transfer:

Verified with patient/legal representative that Advance Directives in medical record are current.	Verified with patient/legal representative that Advance Directives in medical record are current.	Verified with patient/legal representative that Advance Directives in medical record are current.
Signature:	Signature:	Signature:
Date:	Date:	Date:

PATIENT IDENTIFICATION

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Figure 8-9 Advance directive checklist.

Directions for Completing the Advance Directive Checklist

A. Complete the first section as follows:

1. Write patient's name in the designated area and place patient label in lower right corner.
2. Offer a brochure. Check the appropriate box.
3. Indicate from whom the information was obtained: Patient or Other.
   If "Other", indicate the relationship to the patient.

B. Information for the second section may come from someone other than the patient.

1. Ask which (if any) advance directives the patient has executed and verify currency. Check all boxes that apply.
2. If a copy is provided check the box in the "Copy Received, This Admit" column across from the specific advance directive. If a copy was provided prior to this visit, check the appropriate box in the "Copy Received, Prior Admit" column. If neither, ask for a copy and check the "Copy Requested" column.

C. Information for the third section must be obtained from the patient.

1. If the patient has not executed advance directives, ask if the patient would like more information (in which case, Social Services should be notified) or if the patient chooses not to execute advance directives at this time. Check the corresponding box.
2. Advise the patient of his/her rights as listed on the form, check each box as you read each right, and list the date in the space provided.

D. Fourth section to be completed by Home Health/Hospice admitting RN.

E. Sign the form, indicate your department and date of signing. The patient, or if applicable, the patient's legal representative must sign the form. In the event the patient is mentally competent and able to communicate but physically unable to sign the form, a witness may sign the form. A reason must be indicated describing the physical ailment preventing the patient from signing. The original form is kept in the medical record.

To determine substance of the document, it is best to query the patient in this way:

"Mr./Mrs. _____ , I understand you have a Living Will/MPOA.....Can you tell me what it says?" (If the patient is unable to indicate this, offer to have them execute new documents and refer to Social Services.)

F. The final section should be completed by any PHCT member receiving the patient upon admit/re-admit or transfer. Verify with patient/legal representative that Advance Directives in medical record are current. Signature and date required.

* **Refer to Advance Directives Policy, in the Patient Rights section of the Clinical Policy & Procedure Manual.**

Figure 8-9, cont'd

dictate the interval allowed between notations (usually daily). The attending physician, residents, hospitalist, and consultants may write on this form. When the EMR is implemented, the physician may enter progress notes directly into the computer or may handwrite them and request that the HUC scan them into the patient's EMR. When paper charts are used the progress notes are kept in the patient binders.

s0115 ***3. Nurse's Admission Record***

p0500 The nurse's admission record (Fig. 8-10) usually precedes or leads into the nurse's notes. On admission to the nursing unit, the patient answers printed questions on the form. A member of the nursing care team also compiles a short nursing history (Hx) from the patient or family member regarding the patient's daily living activities, present illness, and medications the patient is taking. Also recorded on the nurse's admission history form are the patient's vital signs, height, weight, and any allergies to food or medications. When the EMR is implemented, the nurse enters the admission information, including patient allergies, height, and weight, directly into the patient's EMR. The clinical decision support system then provides an allergy alert on the ordering screen if the doctor orders a medication for which a patient allergy has been documented. When paper charts are used, the HUC enters this vital information, including height, weight, and allergies, into a patient profile screen on the computer. It is a responsibility of the HUC to label the front of the patient's chart with an **allergy** sticker. It is standard practice in some facilities to use red ink to note patients' allergies on chart forms including the patient's medication administration record (MAR) and Kardex (discussed in Chapter 9). If the patient has reported having no known allergies **(NKA),** that is also noted. **NKDA or NKMA** may be used to indicate no known drug or medication allergies on the MAR. A patient's food allergy or no known food allergies **(NKFA)** would also be noted on chart forms including the patient's Kardex and MAR and the nutritional care department would be informed. Some facilities provide a separate allergy form that is included under the hard cover of the chart binder. When using the EMR or paper chart, the HUC places an insert into a plastic **allergy bracelet** for the patient to wear.

4. Nurse's Progress Notes or Flow Sheet

s0120 The nurse's progress notes are a standard chart form that is
p0505 used to outline the patient's care and treatment and to record the treatment, progress, and activities of the patient. The nurse's observations of the patient are recorded on the nurse's progress notes. Entries must be dated, timed, and signed by the nurse who is making the entry; the signature usually includes the nurse's first name, last name, and professional status (RN, LPN). These notes relate to the patient's behavior and reaction to treatment and other care ordered by the physician. The form serves as the written communication between the doctor and the nursing staff. When the EMR is implemented, the nurse's progress notes are entered directly into the patient's EMR. The nurse may use portable computers (discussed in Chapter 4) to enter information into the EMR at the patient's bedside. The form is used during patient care conferences to evaluate patient progress and to plan discharge and future care.

p0510 When paper charts are used the form is often located on a nurse's clipboard, outside the room in a chart rack or the WALLaroo. Nursing students, registered nurses (RNs), licensed practical nurses (LPNs), and, in some facilities, certified nursing assistants (CNAs) may record on this form. Black ink is preferred for all shifts because colored ink, especially red and green, does not photocopy or microfilm well.

5. Medication Administration Record

s0125 When the EMR is implemented, medications are entered
p0515 directly into the patient's computerized medication record when the doctor orders them. The nurse enters documentation regarding administration of those medications on the patient's computerized medication record.

p0520 When paper charts are used, all medications given by nursing personnel are recorded on a medication administration record (MAR). As the doctor orders new medications, the date, drug, dosage, administration route, and time and frequency of administration of the medication are written on this form. This may still be a part of the transcription procedure and is sometimes a task for the HUC in some health care facilities. Some hospital pharmacies provide a computerized medication record for every patient each day. When a new medication is ordered, the nurse or HUC handwrites the name of the medication with administration instructions on the computerized form. Pharmacy personnel will add the new medications to the following day's printed MAR from the copy of the doctors' orders sent by the HUC.

6. Nurse's Discharge Planning Form

s0130 The nurse's discharge planning form is used to prepare the
p0525 patient for discharge from the health care facility (see the Evolve website). The nurse usually records information about the patient's health status at the time of discharge and provides instructions for the patient to follow after discharge from the health care facility. When the EMR is implemented, the nurse enters information and instructions directly into the patient's EMR. When paper charts are used, the form is kept in the patient's chart. When the patient is discharged, the HUC or nurse prints the discharge instructions from the computer or photocopies the handwritten form to give to the patient.

7. Physician's Discharge Summary

s0135 The physician's discharge summary is used by the physician to
p0530 summarize the treatment and diagnosis the patient received while hospitalized, and it includes discharge information. A coding summary or diagnosis-related group (DRG) sheet may be part of the physician's discharge summary, or it may be a separate chart form.

p0535 When the EMR is implemented, the physician enters the discharge summary directly into the patient's EMR; and when paper charts are used, the form is kept in the patient's chart.

Standard Patient Chart Form Initiated by the Physician

s0140

History and Physical Form

s0145 The history and physical (H&P) form is used to record the
p0540 medical history and the present symptomatic history of the patient. A review of all body systems or physical assessment of the patient is also recorded. When the EMR is implemented, the doctor, hospitalist, or resident may enter information directly into the patient's EMR; alternatively, the health care provider may dictate the information so the medical transcriptionist can enter it into the patient's EMR. When paper charts are used, the H&P form is usually dictated by the patient's doctor, hospitalist, or resident.

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Nursing Admit Data Form - Adult Patient

PATIENT STORY

Pain /Comfort Evaluation: Check all that apply

Frequency: ☐ None ☒ Currently have ☐ Acute ☐ Chronic
Onset / Duration _____
Type: ☐ Constant ☒ Intermittent ☐ Sharp ☐ Dull ☐ Burning
☐ Crushing ☐ Stabbing ☒ Radiating ☐ Other _____
Pain Severity 3 Location: LOWER LEGS - RIBS
Pain Scale: ☒ Numeric ☐ Wong-Baker ☐ Objective Sign/Symptom
If using OS/S, document values: _____
What makes it better? MEDICATION
What makes it worse? MOVING

Substance Use (per patient) **Info is Unknown or UTA** ☐
Tobacco: ☒ No ☐ Yes (answer the following) ☐ Smoke ☐ Chew
Amt per day: _____ # of years _____ If quit, when _____
Alcohol: ☒ No ☐ Yes (answer the following) Last drink _____
What kind: _____ Amt: _____ Frequency _____
Drugs: ☒ No ☐ Yes (answer the following) Last used _____
What kind: _____ Frequency _____

Emotional / Spiritual / Religious **Info is Unknown or UTA** ☐
Religion / faith DO NOT PUBLISH ☐ None
Requesting Chaplain visit ☐ No ☐ Yes ☐ Chaplain notified (ext5437)
What spiritual /cultural practices/beliefs would you like supported while being hospitalized _____ ☐ None
How can we support these _____ ☐ N/A
Are there any concerns that are troubling you while being hospitalized?
☐ Finances ☐ Job ☒ Insurance ☐ Housing ☐ Child care ☐ Pay for meds
☐ Homeless ☐ None ☐ Other _____

Educational **Info is Unknown or UTA** ☐
Does the patient indicate he/she is motivated to learn? Yes ☒ No ☐
How does the patient best learn? ☐ Video ☐ Discussion ☒ Reading
☐ Audio tapes ☐ Pictures ☐ Demonstration ☐ Other _____
Based on the above, are there any barriers to learning ☒ No ☐ Yes
Describe _____
If yes, what alternatives to barriers are being suggested _____

Communication **Info is Unknown or UTA** ☐
Language at home: ☒ English ☐ Spanish ☐ Other (identify below)
_____ (don't forget sign language)
Able to speak: ☒ Y N Write: ☒ Y N Read ☒ Y N
Visual Impairment? ☒ No ☐ Yes ( ) R ( ) L ( ) UTA
Hearing Impairment? ☒ No ☐ Yes ( ) R ( ) L ( ) UTA
Was an interpreter used ☒ N/A ☐ Yes Name _____
Language spoken ENGLISH

Outcomes Management **Info is Unknown or UTA** ☐
Anticipate D/C to ☒ Home ☐ Nursing Home ☐ Rehab Facility ☐ Hospice
☐ Correctional Facility ☐ Foster Care ☐ Other _____
Who will care for patient at D/C ☒ Self ☐ Spouse /SO ☒ Family
☐ Attendant ☐ Other _____
May need: HomeHealth ☒ No ☐ Yes Community Resources ☐ No ☐ Yes

NOTIFICATIONS

Social Service Notified via STAR ☒ N/A ☐ Yes Date/ time _____
Rehab Services notified (0945) ☒ N/A ☐ Yes Date/time _____
Form faxed (5453) to Pharmacy ☐ Yes ☒ No, why? _____

If an area in blue has been checked, order a Social Service referral
If an area in green has been checked, order a Rehab referral
Do not forget to fax this page to the pharmacy
If an area in pink has been checked, initiate the Pneumococcal and influenza pre-printed order form

Prior Level of Function **Info is Unknown or UTA** ☐
In the last 3 months pt was ☒ Independent
☐ Partial Care ☐ Total Care
In the last 3 months pt has needed help with
☒ NA ☐ Ambulation ☐ Bathing ☐ Eating ☐ Dressing
☐ Transferring ☐ Toileting ☐ Other _____
If any green area has been checked order a Rehab referral

Circle if a concern or deficit in an area seems to be present Info is Unknown or UTA ☐

Mobility	Balance	Ambulation
Upper Extremity	Lower Extremity	ADLs
Self Care	Cognition	Swallow

If any green area has been checked order a Rehab referral
Circle what medical equipment is used at home

Wheelchair	Ostomy	Walker
Cane	Crutches	Oxygen
Venous access device	Glucose Meter	Feeding tube
Foley	Suprapubic	Ostomy

Other _____

Immunizations – Info is Unknown or UTA ☐
If any pink highlighted area has been checked, the patient should be offered pnuemo / flu vaccine. See Pneumococcal and influenza pre-printed order form for details
Patient 65 or older? ☒ Yes ☐ No
Pnuemovac: ☐ Yes When? _____ ☒ No
Current diagnosis of Pneumonia ☐ Yes ☒ No
Influenza: ☐ Yes When? _____ ☒ No
Tetanus: ☒ Yes When? 2005 ☐ No

Medical History: **Info is Unknown or UTA** ☐
Per: ☒ Patient ☐ Family ☐ Chart
Frequent admissions due to inability to meet the expense of medication: ☐ Yes ☒ No
Dates of previous hospitalizations/surgeries: _____
2005 - PNEUMONITIS

# of ED visits or clinic visits in the last 6 months: 8
Circle all that apply. If circled, you may provide additional detail in narrative area below

Alzheimer's/Dementia:	Psychiatric	Depression
GI Bleeds/Ulcer:	Heart Disease	Hepatitis
Arthritis/Osteoporosis	Asthma/COPD	HIV / AIDs
Blood Disorders	Emphysema	Diabetes
Sickle Cell	Chronic Alcohol	Cancer
Hepatitis / Cirrhosis	Spleenectomy	Stroke
Blood Transfusions	Kidney Problems	Thyroid
Current Pregnancy	Substance abuse Rehab	TB
Chronic Immunosuppresion	Other _____	

Is there anything else the patient or family thinks would be helpful for us to know in order to plan the care for this patient?
☒ No ☐ Yes _____

_____ _____
Printed Name / Credentials Signature / Credentials / Initials

_____ _____
printed Name / Credentials Signature / Credentials / Initials

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Figure 8-10 Nurse's admission record.

Continued

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Nursing Admit Data Form - Adult Patient

PATIENT STORY

DT102

Date/Time 6/10/1800 Unit 3E Room # 306 Age 67
Admit Dx: MVA - DIABETES
Addl Dx: HYPERTENSION
Height 182 cm (1 in /2.54 cm) Weight 89 kg. (2.2lb/ kg.)
☐ Stated ☐ Bed scale ☐ Standing scale ☐ Other
Emergency Contact: Name / Phone / Relationship to patient
1. JEAN SOUNDERS - DAUGHTER
2. 102-202-2082
Personal Property ☒ Taken by family ☐ In safe ☐ None
Property at bedside: ☐ Cane ☐ Walker ☐ WC ☒ Glasses /Contacts
☐ Hearing Aids ☒ Dentures: Upper / Lower / Partial
☐ Clothes ☐ Prosthesis
Advance Directives: ☐ None ☒ In Chart ☐ Has Directive but not available
☐ Refused info ☐ Info given to
Type: ☐ Advance directive ☐ Living will ☐ POA (medical)
What is the patient/family's intent if Advance Directive not available?

A Social Service referral may be needed to help pt / family (ext. 5321)
Social Services notified ☐ Yes Date/ time ☐ N/A
Allergies: ☒ No known **Info is Unknown or UTA** ☐
☐ Iodine (reaction) ☐ Tape (reaction)
☐ Latex (reaction)
☐ Meds (List/reaction)
☐ Food (List/reaction) N/A
☐ Other (List/reaction)
Allergy Band applied? ☐ Yes ☐ No, why?

Safety Alerts: ☐ Fall ☐ Skin ☐ Seizure ☐ Aspiration ☐ Flight ☐ None
☐ Harm to self ☐ Harm to others ☐ Isolation (type)

Nutrition: Diet at home: DIABETIC Last ate at 1200

Poor oral health	☐ Yes	☒ No	☐ Yes	☐ No
Tube Feeding/TPN			☐ Yes	☐ No
Vomiting, nausea, clear liquids or NPO >3 days			☐ Yes	☐ No
Modified Diet (such as Low Sodium, Diabetic, Renal)			☐ Yes	☐ No
New Diabetic	☐ Yes	☒ No		
Breastfeeding			☐ Yes	☐ No
Pregnant	☐ Yes	☐ No		
Decubitis III / IV			☐ Yes	☐ No

Surgical patient and over 70 years ☐ Yes ☐ No
Difficulty with chewing or swallowing ☐ No ☐ Yes. why
Unplanned weight loss within last 3 months of 10+ lbs. ☐ Yes ☐ No
If any yellow area has been checked order a Nutrition referral

Domestic Violence Do you feel safe in your home? ☒ Yes ☐ No ☐ None
Do you feel safe in your current relationship? ☒ Yes ☐ No ☐ None
Do your children feel safe in your current relationship ☒ Yes ☐ No ☐ None
If any blue area has been checked order a Social Service referral

Oriented to unit:	☒ Call light	☒ Bed Controls
☒ Phone/TV	☒ Mealtimes	☒ ID bands
☐ Smoking Policy	☒ Visiting Hours	☒ Side rails
☒ Pain Assessment Chart	☐ Isolation rules	☐ Hand washing
Info given to: ☐ Patient	☒ Family	☐ Unable to

NOTIFICATIONS
Nutrition Services faxed (1203) ☒ N/A ☐ Yes Date/time
Social Service Notified via STAR ☒ N/A ☐ Yes Date/time
Form faxed (5453) to Pharmacy ☒ Yes ☐ No. Why?
Infection Control Called (5276) ☒ N/A ☐ Yes Date/time

If an area in yellow has been checked, order a Nutrition referral
If an area in blue has been checked, order a Social Service referral
Do not forget to fax this page to the pharmacy
If an area in pink has been checked notify Infection Control

Briefly describe the events that led to the admit
(Include where patient arrived from, ie: ED, PACU, home)
ADMITTED FROM ER
STATUS POST MVA

Brief Social History / Support System
SEPARATED FROM WIFE FOR 5 YRS. HAS ADULT CHILDREN LIVES WITH DAUGHTER

Referred to Social Services ☒ N/A ☐ Yes Date/ time
Reason

List the medications the patient is taking including dose and frequency
Remember OTCs & Herbal supplements
AVALIDE 300/12.5 mg 1 PO QD
LIPITOR 40mg 1 PO QD
GLYBURIDE 5mg 1 PO QAM

Other / Updates:

Printed Name / Credentials
Signature / Credentials / Initials

2155 (07/04)

Figure 8-10, cont'd

A medical transcriptionist in HIMS types the dictated report and sends it to the nursing unit to be placed in the patient's chart. The H&P form may be completed after the patient has been admitted to the hospital. Some doctors send a completed copy of the patient's H&P form with the patient, or they may send it to the hospital before the time of the patient's admission to be scanned into the patient's EMR or to be placed in the paper chart.

HIGH PRIORITY

b0050 In some health care facilities using electronic medical records (EMRs), the health information management services department (HIMS) is responsible for scanning paper forms to the patient's EMR.

s0150 SUPPLEMENTAL PATIENT CHART FORMS

p0550 Supplemental patient chart forms are additional to the standard chart forms according to specific care and treatment provided. For example, if the patient has diabetes, is receiving medication, and is being monitored, the supplemental form called the *diabetic record* is added. When the EMR is implemented, information is entered into the patient's EMR on electronic forms; and when paper charts are used, the forms are inserted into the patient's paper chart. This allows information to be recorded separately from other data, making interpretation easier. It is the responsibility of the HUC to obtain and label (with the patient's ID label) the needed paper supplemental forms and place them behind the appropriate chart divider in the patient's chart binder. If the hospital uses computerized **supplemental chart forms,** the HUC chooses the appropriate patient's name, prints the form with that patient's identification information on the form, and places the forms behind the proper chart divider in the chart binder. Other examples of supplemental patient chart forms include the following:

s0155 Clinical Pathway Record Form

p0555 Most hospitals use clinical pathway record forms for particular diagnoses or conditions, such as coronary artery bypass graft or total hip or knee replacement. The clinical pathway record form is placed in the chart for those particular patients. The clinical pathway record form includes the surgeon's orders, a plan of care with treatment, and predicted outcomes (Fig. 8-11).

s0160 Anticoagulant Therapy Record

p0560 The anticoagulant record is used to document blood test results and the anticoagulant medication received by the patient who is undergoing anticoagulant therapy. A flow sheet allows the doctor to make a comparison of the patient's blood test results and the medications prescribed over time.

Diabetic Record

s0165 p0565 The diabetic record is placed in the charts of patients who are receiving medication for diabetes (see Evolve). Results of the blood tests performed to monitor the effects of diabetic medications are also documented on the diabetic record.

Consultation Form s0170

The patient's attending physician may wish to obtain the opinion of another doctor. In this event, the physician requests a consultation by writing it on the doctor's order sheet. Most doctors dictate their report on completion of the consultation. The hospital medical transcription department types the dictated report and sends it to the nursing unit to be filed in the patient's paper chart. Some doctors may prefer to write their findings on a consultation form. Additional information regarding consultations is presented in Chapter 18. p0570

Operating Room Records s0175

The number of forms required for maintaining a record of a patient's operation varies; these forms are usually assembled into a surgery packet. Such records are used by the preoperative department, anesthesiologist, operating room staff, and recovery room personnel). Additional responsibilities regarding the surgery chart are discussed in Chapter 19. p0575

Therapy Records s0180

Health care facilities use individual record sheets for recording treatments. It is possible to have record sheets for physical therapy, occupational therapy, respiratory care, diet therapy, radiation therapy, and others. These departments are discussed in Section Three of this text. p0580

Parenteral Fluid or Infusion Record s0185

A parenteral fluid record is placed in the chart of a patient who receives an intravenous infusion. This form, when completed, is a written record of types and amounts of intravenous fluids administered to the patient. If bedside charting is in use, the parenteral fluid record or vital signs record may be initiated when the information is entered into the computer. p0585

Graphic Record Form s0190

The graphic record form is usually included in the nurse's notes and completed by the patient's nurse, but it may be a separate form in some hospitals and completed by the HUC. The graphic record form is a form used to graph patient vital signs including temperature (Fahrenheit or Celsius), pulse, and respiration (TPR) (discussed in Chapter 10). TPRs are usually taken three times each day or according to specific hospital policy, to monitor the patient's condition. Intake and output and daily weights are also recorded on the graphic record form (Box 8-2, *Recording Vital Signs;* Box 8-3, *Method for Correcting Errors on the Graphic Record in Paper Charts*; Figs. 8-12 and 8-13). p0590

SKILLS CHALLENGE b0055

To practice recording the vital signs and other data on the graphic record, complete Activities 8-3 and 8-4 in the *Skills Practice Manual.* (See Chapter 10 for information regarding vital signs and other data to record on graphic record.)

f00060

History:_____ Procedures:_____

IV:_____

A = achieved - N = not achieved

	Pre-hospital	Date Day of Surgery	Date Post-op day 1	PO day 2	PO day 3	PO day 4 Discharge
Consult	Medical Clearance if necessary	PT consult in PM	PT therapy BID	PT BID Home Care and SS as appr	PT BID	PT
Tests	CXR, CBC, UA, PT, SMA20, EKG, Labs appropriate for age & health 72 hrs before	T & C 2 units (pre-op) (autologous when able) X-ray (in PACU)	H & H ☐ PT (if on coumadin) ☐	H & H ☐ PT ☐	H & H ☐ PT ☐	PT ☐
Mobility		dangle - stand prn	Knee exercises Chair BID (30 min) - up for dinner Stand/Amb_____	Cont exercises - Amb BID Chair BID (45 min) - up for lunch and dinner BRP	Continue mobility Chair (60 min) - up for all meals	Continue mobility Chair (60 min) - up for all meals
Treatments		Trapeze Drain IV therapy, incentive spir q2° DVT prophylaxes : (TED, foot compression device, coumadin , Lovenox) CPM 0 - 40° in PACU	Trapeze Drain Cap IV, incentive spir q2° DVT prophylaxes CPM 0 - 50°	Trapeze DC drain Cap IV, incentive spir q2° DVT proph Dressing change by physician CPM 0 - 60°	Trapeze Incentive spirometer DC IV DVT proph CPM 0 - 70°	CPM 0 - 80°
Meds		Pain Med (IV, IM) Pt states pain relief: A N Antibiotics	Pain Med (IV, IM) Pt states pain relief: A N DC Antibiotics	PO pain meds Pt states pain relief: A N	PO pain meds prn Pt states pain relief: A N	PO pain meds prn Pt states pain relief: A N
Nutrition Metabolic		DAT_____	DAT_____	DAT_____	DAT_____	DAT_____
Elimination		Catheter of choice prn st cath _____ foley after 3rd time	DC foley	Eval. bowel function (BCOC)	Bowel movement: A N	Bowel movement: A N
Health /Home Management			Screen for Home Care & Social Service needs	Prescription for home equipment identified by PT Order equipment	Complete transfer form	☐ Home ☐ ECF
Health Perception	TKA pre-op teaching by Interdisciplinary Team	Review: ☐ TCDB, ☐ incentive spirometry, ☐ ankle pumps, ☐ ROM to arms, ☐ CPM, ☐ pain management	Instruct on: ☐ knee precautions	Instruct on: ☐ incisional care ☐ pain management	Discharge teaching: ☐ Medication ☐ review knee book	☐ Written discharge instructions to patient and family
Signature						
Signature						
Signature						

Outcomes			Date met/initials	Outcomes	Date met/initials
1. In-out of bed	☐ indep or with min assist	☐ mod - max assist		5. Evidence of wound healing, no drainage	
2. On-off commode or chair	☐ indep or with min assist	☐ mod - max assist		6. Performs total knee exercises without assistance	
3. Ambulates with assistive devices.	☐ 75 feet indep or with min asst	☐ 50 feet		7. Re-establish elimination pattern.	
4. AROM	☐ 0 - 70 - 90°	☐ 0 - 60°		8. Utilizes oral analgesics for pain control.	

Figure 8-11 Clinical pathway (care plan with treatment and predicted outcomes) for total knee arthroscopy.

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BOX 8-2 RECORDING VITAL SIGNS

b0090 The graphing of vital signs is usually completed by the patient's nurse. In some hospitals using paper charts, the nursing personnel record patient vital signs on a temperature, pulse, and respiration (TPR) sheet. It then may be the health unit coordinator's (HUC's) task to record data from the TPR sheet onto each patient's graphic record. The HUC should record vital signs and other data as soon as they are recorded on the TPR sheet, so the information is readily available to doctors when they make rounds to see their patients. Accuracy and timeliness in the recording of vital signs information is a must, because the doctor may use this information to prescribe treatment for the patient. Most often the temperature is taken and recorded using the Fahrenheit scale, but it is sometimes taken and recorded on the Celsius scale, also known as the *Centigrade* scale.

s0195 ### Frequent Vital Signs Record

p0600 The frequent vital signs record is used when vital signs are taken more often than every 4 hours.

s0200 ## CONSENT FORMS

s0205 ### Surgery or Procedure Consent Form

p0605 A number of conditions require the patient or a responsible party to sign a special form granting permission for surgery or other invasive procedures to be performed on the patient (Fig. 8-14).

p0610 Patients who are hospitalized for surgery are required to sign a consent form permitting their doctor to perform the surgery named on the form. This form should not be signed until the physician has explained the surgery or invasive medical procedure and its risks, alternatives, and likely outcomes (informed consent). After having received an explanation, a competent patient can give informed consent.

p0615 Other invasive procedures that require the signing of consent forms by the patient or a responsible party are covered in chapters related to those specific procedures.

p0620 The HUC usually prepares the consent form for the physician or nurse to take to the patient for signature. If the surgery should be cancelled, the surgery permit is still valid unless the doctor or the surgical procedure has been changed.

p0625 Consent forms for surgery and other invasive medical procedures are legal agreements between the patient and the physician. In some health care facilities it may be the physician's responsibility to write the name of the doctor who is to perform the surgery or invasive medical procedure and to write the name of the procedure to be done.

s0210 ### Procedure for Preparing Consent Forms

p0630 In most facilities the HUC prepares the consent form for the nurse or doctor to present to the patient for signature. The following steps assist the HUC in preparing the consent form:

o0220 1. Affix the patient's ID label to the consent form.

BOX 8-3 METHOD FOR CORRECTING ERRORS ON THE GRAPHIC RECORD IN PAPER CHARTS

b0095 Minor graphic errors may be corrected on the original graphic record. However, correction of major errors may require that the original graphic record be recopied. The following procedure for correcting errors should be followed.

1. To correct a *minor error on the graphic portion* of the record, write "mistaken entry" or "error" in ink on the incorrect connecting line, and record your first initial, your last name, and your status above the error; then graph the correct value (see Fig. 8-12).
2. To correct a *numbered entry,* such as the respiration value, draw a line through the entry in ink, and write in ink "mistaken entry" or "error," your first initial, your last name, and your status near it. As close as possible, insert the correct numbers (see Fig. 8-12).
3. To correct a *series of errors* on the graphic record, the entire record must be recopied to show the correct data (see Fig. 8-13, *A*).
   a. Prepare a new graphic record and label with the patient's ID label (see Fig. 8-13, *B*).
   b. Transfer in ink *all* the information onto the new graphic record, including the correction of errors (see Fig. 8-13, *B*).
   c. Draw a diagonal line through the old graphic record in ink, and record in ink on the line "mistaken entry" or "error" (see Fig. 8-13, *A*).
   d. Place the old record behind the recopied record because it must remain as a permanent part of the chart.
   e. In ink, write "recopied," followed by your name, your status, and the date on the new graphic record (see Fig. 8-13, *B*); place the new record behind the correct divider in the patient's chart.

2. Write in black ink the first and last names of the doctor who is to perform the surgery or invasive medical procedure. o0225
3. Write in black ink the surgery or invasive medical procedure to be performed exactly as the physician wrote it on the physician's order sheet, except that abbreviations must be spelled out. For instance, if the doctor's order reads "amp of rt index finger," the consent form should read "amputation of the right index finger." o0230
4. Spell correctly, and write all information legibly o0235
5. Do not record the date and time. The person who obtains the patient's signature will enter the date and time. o0240

p0660 The patient may be required to sign other permit or release forms during hospitalization. Following are examples of situations that usually require a signature by the patient or by the patient's representative:

1. Release of side rails o0245
2. Consent to receive blood transfusion (Fig. 8-15) o0250

o0255 3. Refusal to permit blood transfusion (Fig. 8-16)

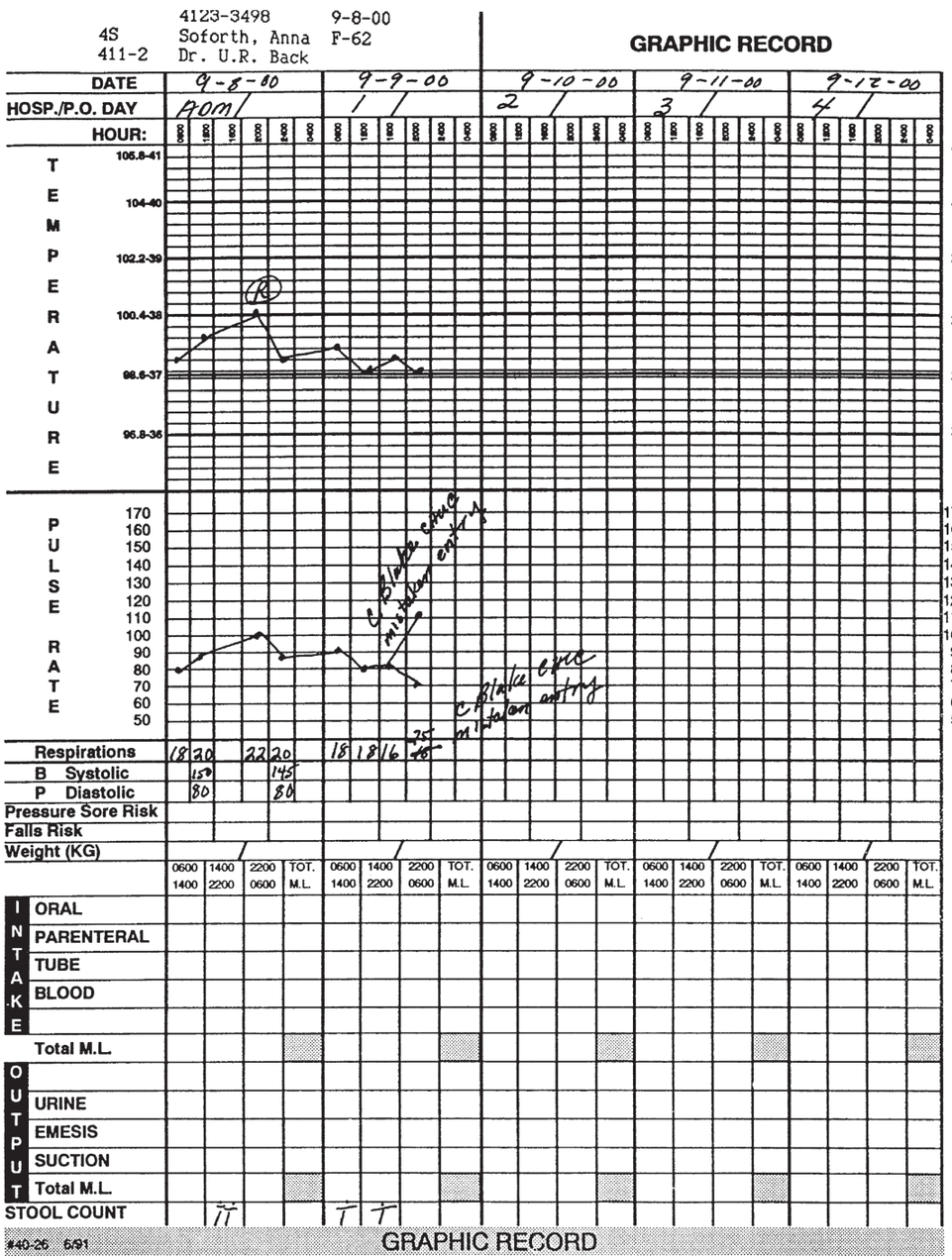
o0260 4. Consent form for human immunodeficiency virus (HIV) testing (Fig. 8-17)

p0685 When paper charts are used, signed consent forms are filed in the patient's chart. When the EMR is implemented, all printed or handwritten signed consent forms are scanned into the patient's EMR by the HUC.

p0700 Most health care facilities require that only licensed personnel witness the signing of consent forms. Personnel must follow these general rules when asking patients to sign consent forms.

HIGH PRIORITY

When paper charts are used, signed consent forms are filed in the patient's chart. When the electronic medical record (EMR) is implemented, all printed or handwritten signed consent forms are scanned into the patient's EMR by the health unit coordinator. b0060



f0065

Figure 8-12 Correction of minor errors on the graphic record.

b0065

SKILLS CHALLENGE

To practice preparing a consent form for surgery, complete Activity 8-5 in the *Skills Practice Manual.*

o0265 1. The patient must not be under the influence of any "mind-clouding" medications.

o0270 2. The patient must be of legal age (18 years in most states).

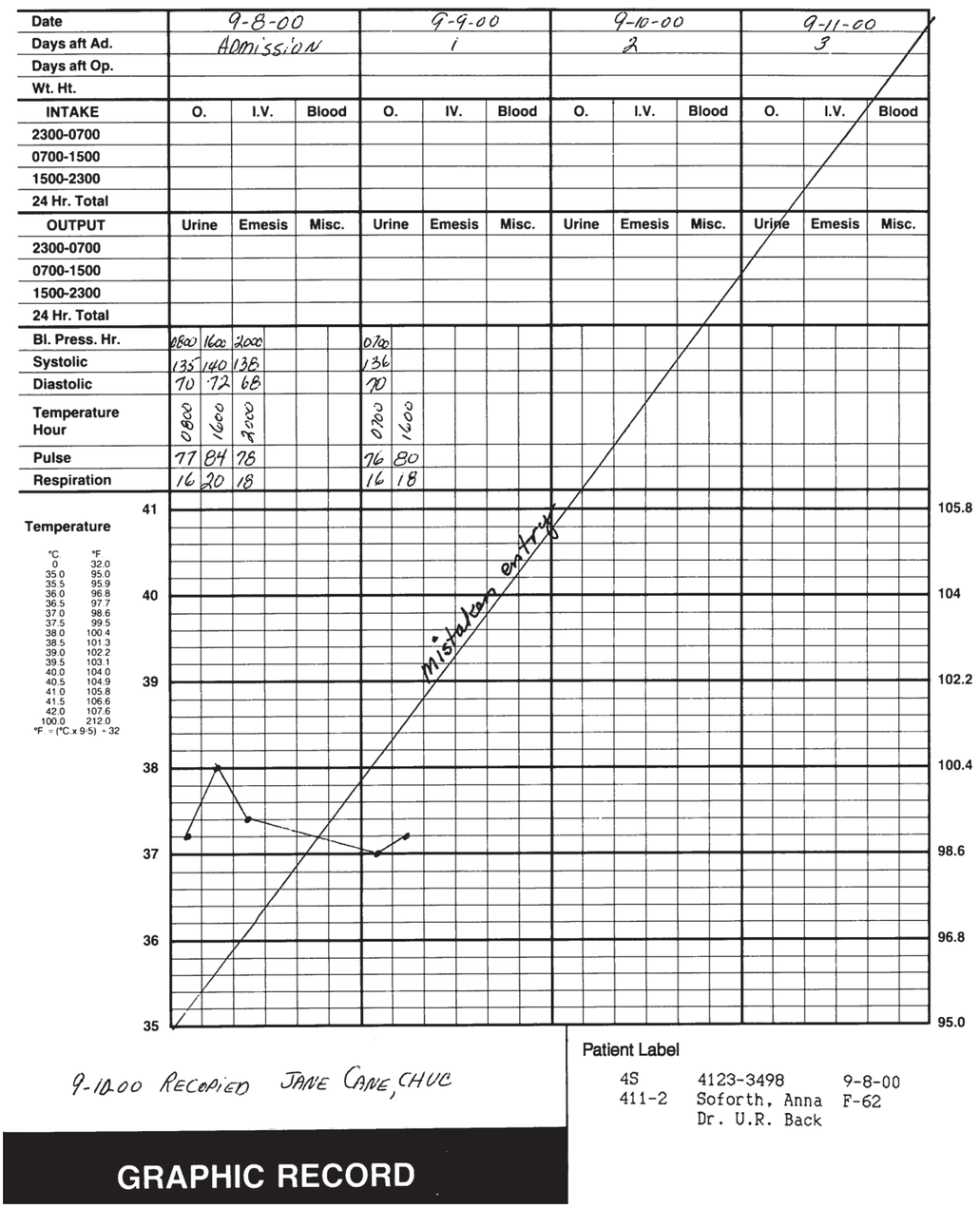
o0275 3. The patient must be mentally competent.

METHODS OF ERROR CORRECTION ON PAPER CHART FORMS

s0215

Because the patient's chart is considered a legal document, information recorded on a chart form must not be erased or obliterated by pen, by covering with a label, or by using liquid correction fluid. Only certain methods of correcting errors recorded on a patient's chart form are permitted. p0720

Patient chart forms that are affixed with the wrong or incorrect ID label may be shredded if no notations have been made p0725



f0070

Figure 8-13 Recopied graphic record used to correct a series of errors. **A,** The original graphic record. **B,** A copied graphic record.

Continued

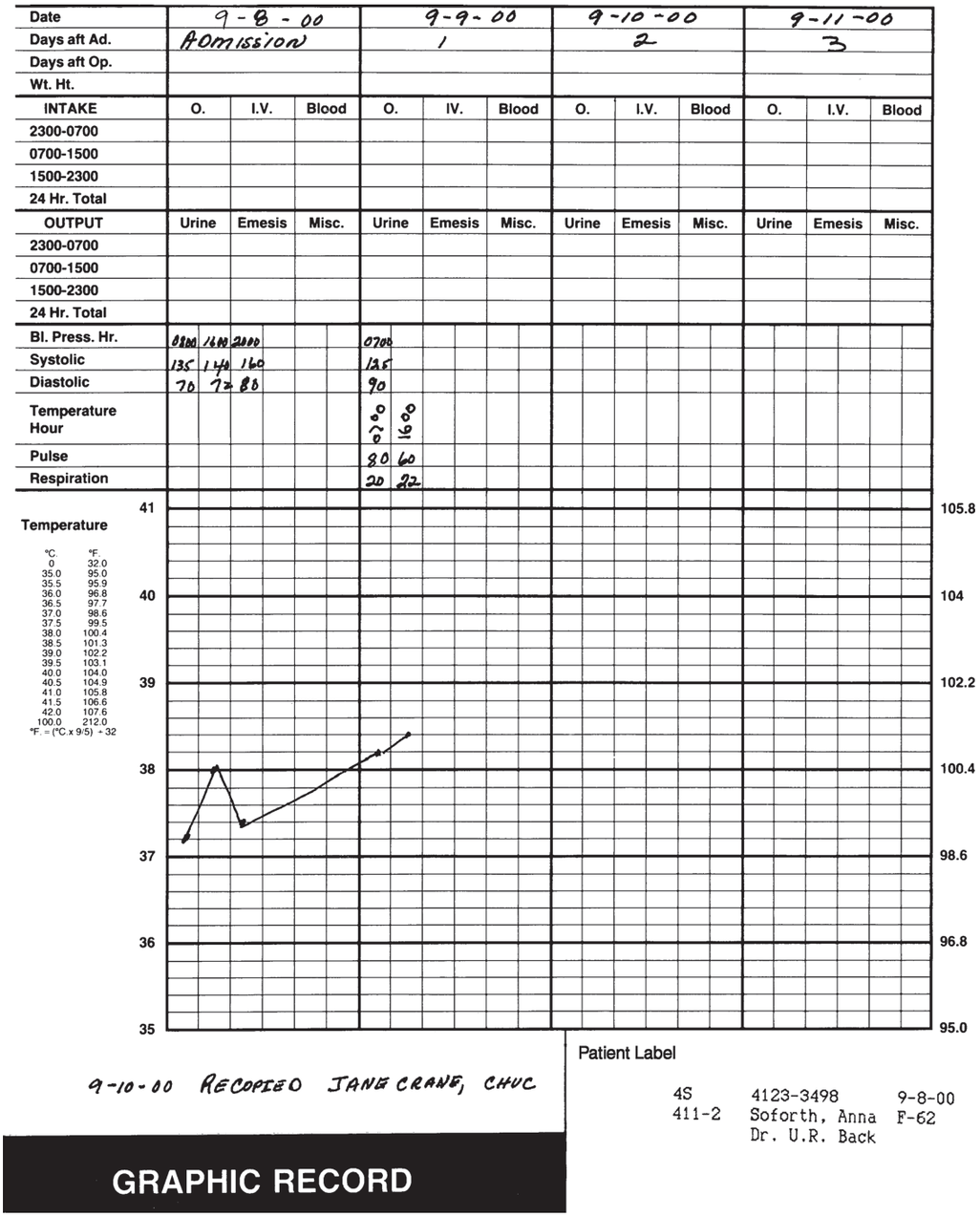


Figure 8-13, cont'd

on them. If a chart form has notations on it, the chart form cannot be shredded. Draw an X with a black ink pen through the incorrect label and write "mistaken entry" with the date, time, and first initial, last name, and status (of the person correcting labeling error) above the incorrect label. Affix the correct patient ID label on the form next to the incorrect label (do not place the correct label over the incorrect label). It is also permissible to hand print the patient information in black ink next to the incorrect label that has an X drawn through it (Fig. 8-18).

p0730 To correct an error in a written entry made on a paper chart form, draw (in black ink) one single line through the error. Record the words "mistaken entry" or "error," along with the date, the time, and your first initial, your last name, and your status in a blank area near (directly above or next to the error) (Fig. 8-19). Follow the facility policy for correction of erroneous computer entries.

HIGH PRIORITY

Errors in care or treatment must be documented on both the EMR and paper chart, and an incident report must be completed, as discussed in Chapter 21. b0070

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0078376	Surg
DOA 01/14/20XX	DOB 05/07/39
67Y M	Dr. Hy Hopes
0	MC/BCBS

CONSENT FOR SURGERY/PROCEDURES/SEDATION/ANESTHESIA

1. I authorize the following operation(s) or procedure(s) **(No Abbreviations)** _____

_____

_____

to be performed by Dr. _____ and/or the associates or assistants of his/her choice, which may include medical or surgical residents. I understand a representative from a medical company, such as a sales representative, may be present during the surgical procedure to provide verbal technical advice to the surgeon, anesthesiologist, and/or staff.

2. During the course of the operation(s)/procedure(s), unforeseen conditions may arise, which may necessitate additional surgery or other therapeutic procedures to promote my well-being. I consent to other surgery / procedures as may be considered necessary or advisable by my physician(s) under the circumstances.

3. I consent to the use of sedation/anesthetics, as may be necessary and advisable,except _____ I understand that sedation/anesthesia may involve serious risk, even though administered in a careful manner. I further understand that a patient should not drive, operate equipment, or drink alcoholic beverages for at least 24 hours after sedation/anesthesia.

4. To further medical and scientific learning, I consent to the photographing and/or video taping of the operation(s)/ procedure(s) that may reveal portions of my body, with the understanding that my identity is not to be revealed. To advance medical education, I give my permission for physicians, nurses, medical students, interns, residents, and other individuals who are participating in an educational process approved by the hospital to be present during the operation(s)/procedure(s).

5. I consent to the examination for anatomical purposes and disposal by the hospital of any tissue or body parts that may be removed during the operation(s)/procedure(s).

6. I understand that some physician(s) performing the operation(s)/procedure(s), administering sedation/anesthesia and those physicians providing services involving pathology and radiology, may not be the agents, servants, or employees of the hospital nor of one another and may be independent contractors.

7. I have been advised that prosthetic devices including, but not limited to, dentures, bridges, caps, crowns, fillings, dental implants, etc. are more easily damaged than normal teeth. I have been advised to remove all removable prosthetic devices prior to surgery, and I agree that responsibility for loss or damage will be mine if I fail to remove such dental or other prosthetic devices.

8. My physician has explained to me the nature, purpose, and possible consequences of the operation(s)/procedure(s) as well as significant risks involved, possible complications, expected postoperative functional level, expected alterations in lifestyle/health status and alternative methods of treatment. I further understand that the explanation I have received is not exhaustive and that there may be other, more remote risks and consequences. I have been advised that a more detailed explanation will be given to me if I so desire. I have received no guarantee or warranty concerning the results/outcome and cure and have been given an opportunity to ask questions, and have my questions answered to my satisfaction.

9. In the event a device is implanted during the operation(s)/procedure(s) and federal law requires the tracking of the device, I consent to the release of my social security number to the manufacturer of the device.

10. The patient is unable to sign for the following reason:

☐ The patient is a minor.

☐ The patient lacks the ability to make or communicate medical treatment decisions because of:

_____

_____ _____ _____

Patient or Legally Authorized Representative Date Time

_____

Relationship to Patient

_____ _____ _____

Witness Date Time

f0075

Figure 8-14 Surgery consent form.

CONSENT FOR TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

1. I HAVE BEEN INFORMED that I need or may need, during treatment, a transfusion of blood and/or one of its products in the interest of my health and proper medical care.
2. I HAVE BEEN INFORMED of the risks and benefits of receiving transfusion(s). These risks exist despite the fact that the blood has been carefully tested.
3. I HAVE BEEN INFORMED that the blood has been tested using all FDA-required, routine tests and that new, unlicensed, and experimental testing may or may not have been performed.
4. The alternatives to transfusion, including the risks and consequences of not receiving this therapy, have been explained to me.
5. I have read, or have had read to me, the Blood Transfusion Information regarding blood transfusions and have had the opportunity to ask questions.
6. I have been given the Paul Gann Safety Act Booklet (CA only).
7. I hereby consent to the transfusion(s).

This consent is valid for the following period of time(check one):

☐ One specific date only: _____

☐ Start Date: _____ End Date: _____

☐ This hospital admission

_____ _____ _____
Patient's Signature Date Time

_____
Signature of parent, legally appointed guardian or responsible person *(for patients who cannot sign)*

_____ _____ _____
Witness Date Time

Consent obtained under the direction of Dr. _____

_____ _____ _____
Physician Signature *(if required by local policy)* Date Time

NOTE:
Refusal form on reverse side
Chart Consent or Refusal Form

Separate "Blood Transfusion Information" sheet and give to patient, parent, or legal guardian.

Williams, John	175-09-02
0078376	Surg
DOA 01/14/20XX	DOB 05/07/39
67Y M	Dr. Hy Hopes
0	MC/BCBS

f0080

Figure 8-15 Consent form for receiving blood transfusion.

b0075

SKILLS CHALLENGE

To practice correcting labeling and written errors on a chart form, complete Activities 8-6 and 8-7 in the *Skills Practice Manual.*

s0220

MONITORING AND MAINTAINING THE PATIENT'S ELECTRONIC MEDICAL RECORD

p0745 The HUC position has changed with the implementation of the EMR, but monitoring and maintaining patients' records is still the responsibility of the HUC.

Health Unit Coordinator Duties for Monitoring and Maintaining the Patient's Electronic Medical Record s0225

1. Monitor the patient's EMR consistently, and complete HUC tasks as required and in a timely manner. o0280
2. Assist nurses, doctors, and ancillary personnel as necessary in entering information and orders into the computer. o0285
3. Report any necessary repairs regarding nursing unit computers and/or printers to the hospital information systems department. o0290
4. Scan documents as required, such as handwritten progress notes, electrocardiograms, outside medical records, o0295

REFUSAL TO PERMIT TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

1. I request that no blood components be administered to _____ during this hospitalization. (patient name)

2. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its components.

3. I fully understand the possible consequences of such refusal on my part.

☐ Physician aware of patient's refusal. Physician notified: _____

Physician notified by:

Signature	Date	Time
Patient's Signature	Date	Time

Signature of parent, legally appointed guardian or responsible person *(for patients who cannot sign)*

Witness	Date	Time
Witness	Date	Time

REFUSAL

Williams, John	175-09-02
0078376	Surg
DOA 01/14/20XX	DOB 05/07/39
67Y M	Dr. Hy Hopes
0	MC/BCBS

f0085

Figure 8-16 Form for refusal to permit blood transfusion.

consent forms, operating room records, and reports, in a timely manner.

o0300 5. Place and maintain patient ID labels in a patient label book.

o0305 6. Place patient face sheets into the face sheet binder, which may be the same as the label book, to provide to physicians as requested.

o0310 7. Always log out of the EMR when not in use to protect patient confidentiality.

s0230 MAINTAINING THE PATIENT'S PAPER CHART

p0790 As the person in charge of the clerical duties on the nursing unit, the HUC is responsible for maintaining the patient's chart.

s0235 Health Unit Coordinator Duties for Effective Maintenance of the Patient's Paper Chart

o0315 1. Place all charts in proper sequence (usually according to room number) in the chart rack when they are not in use.

2. Place new chart forms in each patient's chart before the immediate need arises. In many health care facilities, this is referred to as **stuffing charts.** Label each chart form with the patient's ID label before placing it in the chart. New chart forms are placed on top of old chart forms for easy access. The new forms may be folded in half to show that the old form has not been completely used. o0320

3. Place diagnostic reports in the correct patient's chart behind the correct divider. Match the patient's name on the report with the patient's name within the chart (do not depend on room numbers because patients are often transferred to another room). o0325

4. Review the patient's charts frequently for new orders (always check each chart for new orders before returning the chart to the chart rack). o0330

5. Properly label the patient's chart so it can easily be located at all times. o0335

6. Check each chart to be sure that all forms are labeled with the correct patient's name. Chart forms should be filed in the proper sequence. o0340

CONSENT FOR HIV TESTING

1. My physician, _____, has recommended that I (my child) receive a blood test to detect the presence of antibodies to Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS). I consent to this testing.

   It has been explained to me that in some cases the tests may be positive when I have (my child has) not been infected with HIV. This is a false positive.

   If the screening is positive, a second confirming test is done.

   I understand that a negative result usually means that I have (my child has) not been exposed to HIV. However, there is a possibility of a false-negative result, especially in the time period immediately after exposure to the virus.

2. I have been advised by my physician and I understand the following:
   - Positive test results could mean that I have (my child has) been exposed to the HIV; this would not necesarily mean that I have (my child has) AIDS, or will develop AIDS.
   - That if I am (my child is) HIV positive, I (my child) can transmit the virus to other individuals by sexual contact, by sharing needles, or by the donation of organs, blood, and blood products.
   - That if I am (my child is) HIV positive, I (my child) should not donate blood or blood products, or body organs because the virus can be transmitted to the recipient.

3. I understand that Arizona State Law and Regulations require the reporting of HIV cases to the Department of Health Services and that if my (my child's) test results are positive, they will be submitted to the Arizona Department of Health Services, and others whose authority is established by law, regulation, or court order.

4. I also understand that my request for the test and the test results will be part of my (my child's) hospital medical record and may therefore be requested by others, including insurers, third party payors or other individuals as outlined in the Conditions of Admission.

I have been given the opportunity to ask quesitons, I understand what is involved in HIV testing, and I freely consent to it.

DATE	SIGNATURE
LEGAL GUARDIAN (If patient cannot sign or under age)	WITNESS SIGNATURE

f0090

Figure 8-17 Consent form for human immunodeficiency virus (HIV) testing.

o0345 7. Check the chart frequently for patient information forms or face sheets. Usually five copies are maintained in the chart. Physicians may remove copies for billing purposes. The HUC may print additional copies of the face sheet from the computer or may order them from admitting.

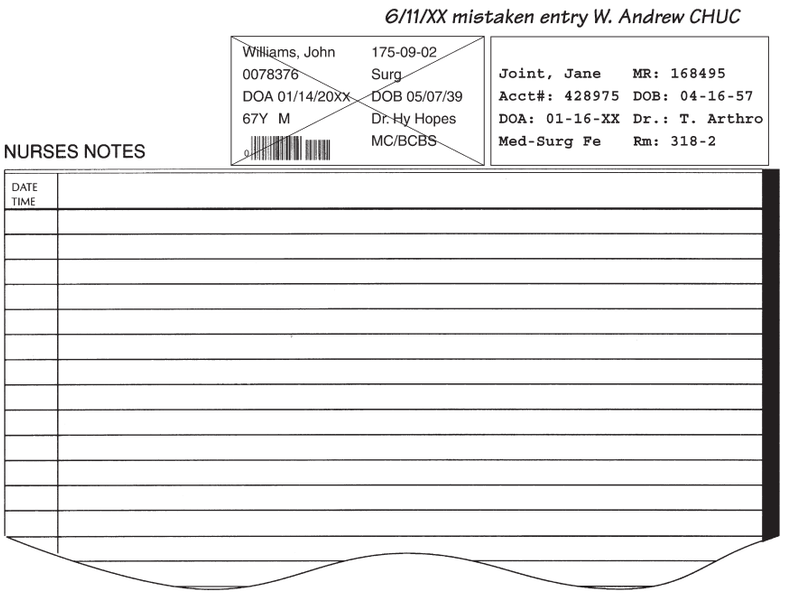
o0350 8. Assist physicians or other professionals in locating the patient's chart.

s0240 Splitting or Thinning the Chart

p0840 The paper chart of a patient who remains in the health care facility for a long time becomes very full and eventually becomes unmanageable. When this occurs, the HUC may **split** or thin the chart. A doctor's order is not required to thin a patient's chart. In thinning the chart, some categories of chart forms may be removed and placed in an envelope for safekeeping on the unit.

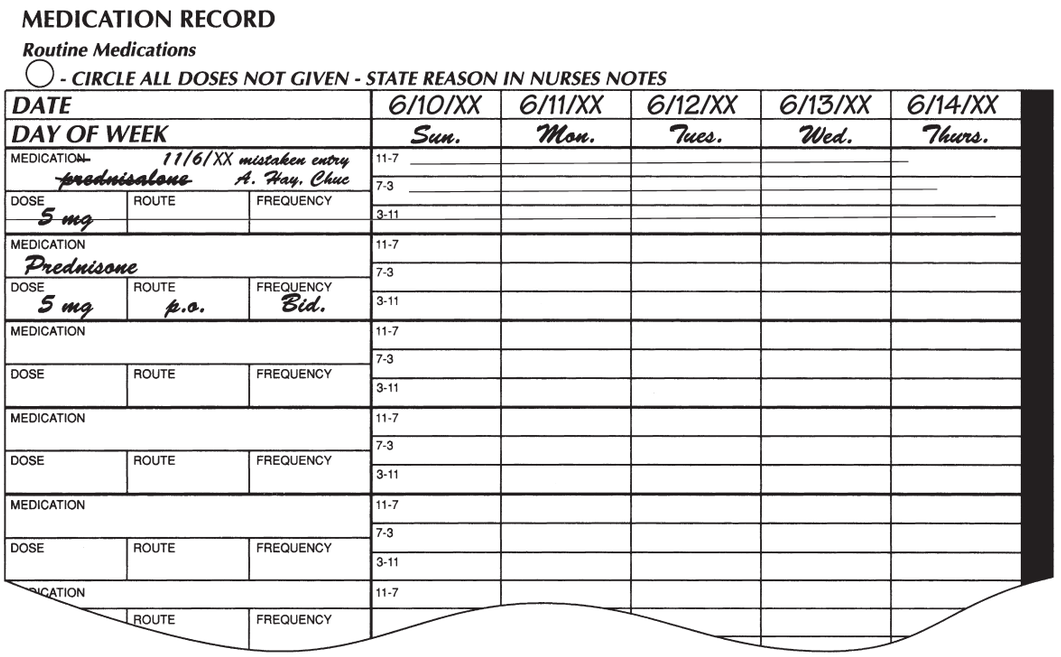
p0845 The following guidelines will assist the HUC in thinning a patient's chart:

1. Remove older nurse's notes, medication forms, and other forms that are no longer needed in the chart binder. (Check the hospital policy and procedures manual to verify forms that may and may not be removed.) o0355
2. Place the removed forms in an envelope. o0360
3. Place the patient's ID label on the outside of the envelope. o0365
4. Write "thinned chart" and record the date with your first initial and your last name (if you are the person thinning the chart) on the outside of the envelope. o0370
5. Place a label on the front of the patient's chart stating that the chart was thinned, along with the date and the first initial and last name of the person thinning the chart. o0375



f0095

Figure 8-18 Method for correcting a labeling error.



f0100

Figure 8-19 Method for correcting a written error on the chart.

o0380 6. If the patient is transferred to another unit, transfer the thinned-out forms with the patient's chart.

o0385 7. When the patient is discharged, send all thinned-out forms with the patient's paper chart to the health information management department.

Reproduction of Chart Forms that Contain Patient Information s0245

Availability of patient medical records is necessary to ensure continuity of care when a patient is discharged to another facility. When the EMR is used, the patient's EMR is available on p0885

computer to other health care facilities, or the records may be printed from the computer. The patient will be required to sign a release form for the records to be available or copied in this situation. When paper charts are used, the records will need to be reproduced using a copy machine. The patient's doctor must write an order specifying the specific chart forms to be copied, and the patient will be required to sign a release form. Depending on hospital policy, the HUC may have the responsibility of copying the paper chart forms, or the patient's chart may be sent to HIMS to be copied. After the forms have been reproduced on the copier, the original forms are replaced in the patient's chart and the copied records are sent to the receiving facility.

HIGH PRIORITY

b0080 After reproducing records, be certain that original records are returned to the patient's binder and the copies are placed in a labeled envelope to be sent to the receiving facility.

s0260 KEY CONCEPTS

p0895 The patient's chart (electronic or paper) is a record of care rendered and the patient's response to care during hospitalization. When the EMR is implemented, all health care information is entered into or scanned into the patient's electronic chart. When paper charts are in use, the nursing unit to which the patient is assigned adds forms to the patient's chart. The patient's medical information (electronic or paper) is a legal record and should be maintained as such.

p0900 Standard chart forms are included in the patient's EMR or placed in all patients' paper charts; supplemental forms may be added according to the need dictated by each patient's treatment and care. The purpose of the forms is the same for each hospital, but the sequence of forms in the chart and the placement of blank forms that are added may differ from hospital to hospital. Information contained in the patient's EMR or paper chart must always be regarded as confidential.

s0250 *Websites of Interest*

p0905 Military time conversion and time table: www.247clocks.com/Military_Time.htm

p0910 "Dos and Don'ts of Nursing Documentation": www.medi-smart.com/nursing-resources/documentation

p0915 U.S. Department of Health and Human Services—"Effective Communication in Hospitals": www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication

p0920 American Management Association official website

p0925 www.amanet.org/

s0265 REVIEW QUESTIONS

p0930 *Visit the Evolve website to download and complete the following questions.*

o0390 **1.** Define the following terms:
o0395 a. stuffing charts
o0400 b. split or thin chart
o0405 c. identification labels
o0410 d. name alert
o0415 e. allergy labels
o0420 f. old record
o0425 g. WALLaroo
o0430 h. admission packet

2. List six purposes for maintaining an EMR or paper chart for each patient. o0435

3. List five guidelines for entering information into a patient's EMR. o0440

4. List five guidelines for writing on a patient's paper chart. o0445

5. List four standard patient electronic or paper chart forms that are initiated in the admitting department, and describe the purpose of each. o0450

6. State the purpose of the following standard forms contained in a patient's electronic or paper admission packet: o0455
a. physician's order form o0460
b. nurse's admission record o0465
c. physician's progress record o0470
d. nurse's progress notes or flow sheet o0475
e. medication administration record (MAR) o0480
f. physician's discharge summary o0485
g. nurse's discharge planning form o0490

7. List the information that is included in a patient's history and physical form. o0495

8. Define what is meant by a *supplemental patient chart form*, and list at least two examples of a supplemental form. o0500

9. Explain the importance of charting vital signs accurately and in a timely manner. o0505

10. Describe how the following errors on a patient's graphic record would be corrected: o0510
a. a minor error on the graphic portion of the record o0515
b. a numbered entry, such as the respiration value o0520
c. a series of errors on the graphic record o0525

11. Discuss the purpose of a consent form, and list five guidelines for preparing consent forms. o0530

12. Describe how patients' medical records are organized and identified when paper charts are used. o0535

13. Convert the following standard times to military times: o0540
a. 3:00 PM o0545
b. 7:15 AM o0550
c. 12:30 PM o0555
d. 1:15 AM o0560

14. Convert the following military times to standard times: o0565
a. 1020 o0570
b. 1940 o0575
c. 1119 o0580
d. 2130 o0585

o0625 **15.** List four types of permit or release forms that a patient may be required to sign during a hospital stay.

o0635 **16.** List seven duties that will assist the HUC in properly maintaining and monitoring a patient's EMR.

o0600 **17.** List eight duties that will assist the HUC in properly maintaining a patient's paper chart.

o0605 **18.** Explain the purpose and process for each of the following:

o0610 a. splitting or thinning a patient's paper chart

o0615 b. stuffing a patient's paper chart

o0620 c. reproducing a patient's paper chart

19. Describe how to correct the following errors on a paper chart form. o0590

a. written entry error o0630

b. labeling error o0595

SURFING FOR ANSWERS s0255

1. Research "Guidelines for retention of patient medical records." List at least three factors to be considered regarding length of time for which patient records should be retained. Provide two websites used. o0640
2. Search the Internet for benefits of using EMRs over paper charts. List at least five and document two websites used. o0645