

Creation of a Hospital Unit Chart Procedure

Summary of Changes: separated from Policy

	NEW	Previous
BC Cancer		HIM 060-IV-10

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1. Introduction

1.1. Focus

This procedure applies to the creation of a hospital unit chart.

1.2. Definitions

Health Record Paper Chart/Soft cover chart (synonymous)

The term "soft cover chart" is used to differentiate the chart from the hard cover chart (the binder on the in-patient unit).

Hard Cover Chart (binder)

The record created at the Nursing Unit for the duration of an in-patient or day care stay which contains all documents received or created during that stay.

Hospital Unit Chart

The record created at the time of patient discharge once the hard cover chart is disassembled, separating documents for filing in the soft cover chart (per order of assembly). The remaining documents mainly consist of handwritten physician notes, nurses' notes and other nursing charting forms.

2. Procedure

2.1. Both the patient's health record (soft cover chart) and the hard cover chart (binder) will remain on the Hospital Unit or with the patient, during the patient's hospital admission or visit.

2.2. At the time of the patient's discharge:

- The Doctors Order Sheet, primary reports, nursing assessment form, and signature sheet are clipped to the front of the patient's health record (soft cover chart).
- The remaining pages of the patient's health record (hard cover chart binder) are stapled together creating the Hospital Unit chart.
- The Hospital Unit chart is clipped to the patient's health record paper chart (soft cover).
- The summary is dictated and transcribed
- Both charts are returned to HIM
- The contents of the Hospital Unit chart which are not included in the patient's longitudinal record are filed in a different chart cover and placed in front of the patient's health record in HIM.

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3. Related Documents

3.1. Policy – Creation of a Hospital Unit Chart

4. References

http://shop.healthcarebc.ca/CST Documents/CSTHealthRecordPolicy.pdf

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