MEDICAL RECORD REVIEW TEACHING SHEET

Medical Record Review Tool for Open & Closed Records

AREAS OF REVIEW (PART I)

ALL ITEMS WILL BE REVIEWED FOR ALL OPEN & CLOSED RECORDS

GENERAL ITEMS FOR ALL PATIENT CARE SETTINGS			
I. 1	Identification data	IM.7-7.2	This is the patient demographic data from Patient Registration at the beginning of each admission. Must have pt's name, address, DOB, name of legal guardian, if any.
I. 2	Appropriate informed consent is documented in the medical record	IM.7.2	This is asking if the Hospital Admission Consent is in the record.
I. 2a	Evidence of appropriate informed consent includes information about the proposed treatment, benefits and drawbacks, alternatives, likelihood of success and problems related to recovery	RI.1.2.1	This is the Hospital Admission Consent form signed by the patient with Patient Registration when admitted. This pertains to the content of what is on the form.
I. 2b	If blood is given, appropriate informed consent is documented in the medical record	IM.7.2	This is a transfusion consent form. Must be present and signed if any blood is given. One form for each admission where blood is given.
I. 3	*If there **is** an indication of advance directives*, the provisions are documented in the medical record	IM.7-7.2	This is only if the patient has Advanced Directives or Durable Power of Attorney and it is in the record.
I. 3a	*In the **absence** of advance directives*, the substance is documented in the medical record; patients who do not have an advance directive are provided information and an opportunity to provide one	RI.1.2.4	This is asking if a patient does not have Advanced Directives, did we give them the opportunity to get information and write Advanced Directives. It is addressed on the Hospital Admission Consent.
ASSESSMENT OF PATIENTS			
I. 4	Assessment includes physical, psychological and social status (for dying patients, this includes spiritual and cultural variables)	PE.1	This is the Nursing Admission Assessment form.
I. 5	History and Physical within 24 hrs of admission	PE.1.7.1	Provider H&P needs to be done, signed & dated within 24 hrs of admission.
I. 6	Medical History, including:	PE.1.7.1	These are the components required on the H&P.
I. 7	Chief Complaint		Patient's complaint or what is wrong with them.
I. 8	Details of present illness		On H&P. Also called History of Present Illness (HPI).
I. 9	Relevant past, social & family histories		Should be addressed on the H&P
I. 10	Inventory by body system		The provider describes each part of patient's system. Will be with the physical.
I. 11	Physical examination		Must be on the H&P.
I. 12	Pain assessment	PE.1.4	"In the initial assessment, pts with pain are identified. This assessment & a measure of pain intensity & quality, appropriate to the pt's age, are recorded in a way that facilitates regular assessment and follow-up."
I. 13	Statement on the conclusions or impressions drawn from the admission history & physical exam	IM.7-7.2	This is the A/P (Assessment/Plan) at the end of the H&P that describes what the provider thinks is wrong with the pt. Might be a list of possible diagnoses, etc.
I. 14	Initial nursing assessment within 24 hrs of admission	PE.1.7.1	Nursing Admission Assessment form must be completed within 24 hrs. of pt admission.
I. 14a	Relevant physical examination is documented	PE.1.7.1	Nursing PE must be done on Nursing Adm Assessment form.
I. 15	The reason(s) for admission of treatment are documented	IM.7-7.2	This is the admission diagnosis. Can be found on the admission orders, the "A" sheet, top of nursing admission assessment.
I. 16	A nutritional screen within 24 hrs and when warranted, an assessment of nutritional status	PE.1.2	This is the nutrition form started by nursing. Top part is completed by nursing and is under the Nursing Admission Assessment form.
I. 17	A functional screen within 24 hrs and when warranted, an assessment of functional status	PE.1.3	This pertains to questions on the Nursing Admission Assessment form that address activities of daily living, use of canes, walkers, etc. Anything that addresses special functional needs of the pt. At present, there is no formal functional screen like the nutrition screen.

I. 18	A functional assessment is performed for each patient referred for rehabilitation services	PE.1.3.1	This is a formal evaluation done by PT. Sometimes there will be a PT assessment/evaluation done on a consultation form or in the progress notes.
I. 19	Need for discharge planning is determined	PE.1.6	Discharge planning must be addressed on admission. Found on the Nursing Admission Assessment form.
I. 20	Each patient is reassessed:	PE.2	Pts are reassessed throughout the care process and at follow-up appointments.
I. 21	Reassessment occurs at regular intervals	PE.2.1	This can be by any discipline. Vital signs, 12 hr nursing forms, RT note/treatment, etc.
I. 22	Reassessment includes a patient's response to care	PE.2.2	Examples: pain meds given, RT treatments given, pt with low BP getting IV fluids to increase BP, etc.
I. 23	A significant change in the patient's condition results in reassessment	PE.2.3	Examples: pt needing to go to ICU, pt having surgery, L&D progress, etc.
I. 24	Have staff members integrated information from various assessments of the patient to identify and assign priorities to care needs?	PE.3	"A pt may undergo many types of assessments from his/her physician and from several other disciplines. There may be a variety of data, analyses et other information. A pt benefits most when staff members work collaboratively to integrate this information into a comprehensive picture." This usually applies to Clinical Pathways and we don't have any yet.
I. 25	Were care decisions based on the identified patient needs and care priorities?	PE.3.1	"From this collaboration, the pt's needs et their order of importance are identified and appropriate care decisions are made."
DOCUMENTATION OF CARE OF PATIENTS			
I. 26	All entries are dated and authenticated according to policy	IM.7.8	IHS Medical Records Policy states authentication requires name and title. 'Authenticated' is defined as: " to verify that an entry is complete, accurate and final."
I. 27	At a minimum, the following entries are authenticated:	IM.7.8	The author authenticates those entries required by hospital policy, but at a minimum, the following: 21-24.
I. 28	Histories and physicals		All admission H&Ps.
I. 29	Consultations		Any consultation in the progress notes or on a consultation form.
I. 30	Operative procedures		Dictated Op Reports, post-op progress notes, Invasive Procedure progress notes.
I. 31	Discharge summaries		Dictated discharge summaries and provider discharge progress notes for stays ? 48 hrs.
I. 32	Verbal orders are dated and timed	IM.7.7	These are the verbal orders taken by RNs or other authorized personnel (pharmacist, PT, RT, Dietician). Must have name, title, date & time.
I. 33	Verbal orders are authenticated within defined time frame when required by law/regulation	IM.7.7	IHS Medical Records policy states verbal orders must be counter-signed within 24 hrs. Bylaws state they can be counter-signed by another MD for the original MD.
I. 34	Goals of treatment & treatment plans are documented	IM.7-7.2	This is any documentation referring to specific treatment goals & plans. Look for goals & treatment plans in the nursing Patient Problem List or the provider H&P.
I.34a	Care planning considers patient-specific needs, age-specific needs, severity level of condition and impairment	TX.1	"Care is planned to respond to each patient's unique needs, expectations and characteristics with effective, efficient and individualized care." Care planning documentation will be in the nursing Patient Problem List or progress notes.
I. 35	Clinical observations, including the results of therapy	IM.7-7.2	This refers to any written observation about pt care and includes MDs writing the results of labs, x-rays ordered.
I. 36	Progress notes made by the medical staff and other authorized staff	IM.7-7.2	Documentation of pt care must be made in the progress notes by all disciplines.
I. 37	Consultation reports, if applicable	IM.7-7.2	If a consultation is ordered, is it done and documented. Can be a formal consultation form in the front of the admission or on a progress note.
I. 38	Monitoring of a medication's effect on the patient includes assessment based on collective observations, including the patient's own perception of its effect	TX.3.9	"Monitoring medication effects on patients is a collaborative process. Assessment of the medication's effect on the patient includes the patient's own perceptions and information from the patient's medical record & medication profile." Find documented patient response to medication given. Look for notes, vital signs, EKGs, etc. that show monitoring of the effect of a specific med given. (Ex: heart, BP, pain med)
I.38a	Every medication ordered or prescribed for an inpatient is documented in the medical record	IM.7-7.2	All meds ordered are transcribed on the MAR. All IV's ordered are on the IV fluid sheet. RT meds are on the MAR. The MAR is the sole source of coordinating meds given.
I. 39	All diagnostic and therapeutic procedures & test results, such as pathology & clinical laboratory exams & radiology & nuclear medicine exams or treatments	IM.7-7.6	This is to ensure that all the lab, radiology and nuclear medicine (CT, MRI) reports are on the chart during admission. For complex radiology procedures, there will be a handwritten procedure note from the Radiologist in the progress note followed by a formal report. (Procedures like CT, US, fluoro, imaging-guided biopsies)
EDUCATION			
I. 40	Patients' learning needs, abilities, preferences & readiness to learn are assessed	PF.1	"Openness and flexibility are important elements in patient education and can make a critical difference in whether the pt follows instructions. In assessing a pt's needs, abilities and

I. 41	The assessment considers cultural beliefs, religious beliefs, and barriers to learning (e.g. emotional, physical & cognitive)	PF.1.1	pt follows instructions. In assessing a pt's needs, abilities and readiness for education, staff members take into account such variables as: pt's/family's beliefs & values; their literacy, educational level & language; emotional barriers & motivations; physical & cognitive limitations, and the financial implications of care choices." This is found on the Interdisciplinary Teaching Sheet.
I. 42	*When called for by the age of the patient & length of stay*, school-aged children are given the opportunity to continue their schooling	PF.1.2	"Although the hospital may not provide school teachers directly, it is responsible for providing access to schooling, according to state education law."
I. 43	*When appropriate*, the patient is educated about the safe & effective use of medications	PF.1.3	This is found on the pharmacy computer discharge medication printout and/or the Patient Discharge Instruction sheet. May find specific note in progress notes.
I. 44	*When appropriate*, the patient is educated about the safe & effective use of medical equipment	PF.1.4	This could be in the progress notes, PACU nursing form (like for a PCA pump), possibly on the PCA charting form. May be on the 12-hr nursing form or Interdisciplinary Teaching sheet.
I. 45	*When appropriate*, the patient is educated about diet & nutrition, including potential drug-food interaction	PF.1.5	Any diet/nutrition teaching would be on the Interdisciplinary Teaching sheet, the Patient Discharge Instruction sheet. The drug-food interaction is a stamp placed by Pharmacy on the back of a Doctor's Order page with date/time/pharmacist.
I. 46	*When appropriate*, the patient is educated about rehabilitation techniques	PF.1.6	This would be done by PT and would specifically be in the progress notes. Might also be on a consultation form from PT.
I. 47	*When appropriate*, the patient is educated about pain & effective pain management	PF.1.7	Any documentation about pain meds. Look at discharge or specific procedures while in hospital.
I. 48	*When appropriate*, the patient is educated about available community resources	PF.1.8	This is any teaching done or referrals made to specific community resources (ex: WIC, PHNs, etc.)
I. 49	*When appropriate*, the patient is educated regarding personal hygiene & grooming	PF.1.11	"With due regard for privacy, the hospital teaches & helps pts maintain good standards for personal hygiene & grooming, including bathing, brushing teeth, caring for hair & nails, and using the toilet." This is documented on the 12-hr nursing form.
I. 50	Was the educational process interdisciplinary as appropriate to the care plan?	PF.4.2	"When health care professionals understand one another's contributions to pt education, they can collaborate more effectively. Collaboration, in turn, ensures that the information pts/families receive is comprehensive, consistent and as effective as possible." This is asking if multiple disciplines are documenting on the Interdisciplinary Teaching sheet.
DISCHARGE INFORMATION			
I. 51	Conclusion at termination of hospitalization	IM.7-7.2	This is the discharge diagnosis & the pt's condition, etc. Will be on the Patient Discharge Instruction sheet.
I. 52	Clinical resumes and discharge summaries	IM.7-7.2	This is the dictated discharge summary from the provider. For stays ? 48 hrs, there is no dictated summary, but should have a provider's discharge note.
I. 53	Discharge instructions to the patient and/or family	IM.7-7.2	This is found on the Patient Discharge Instruction sheet. Every discharged pt should have this form.

AREAS OF REVIEW (PART II)

ADDITIONAL STANDARDS TO BE REVIEWED FOR SPECIFIC PATIENT POPULATIONS

OPERATIVE & OTHER INVASIVE PROCEDURES			
II. 1	History & Physical documented prior to procedure	PE.1.8	All OR procedures must have an H&P that is no longer than **8 days old**. Other invasive procedures must have current H&Ps for that admission.
II. 1a	Pre-op diagnosis by LIP	IM.7.3.1	There must be a formal, pre-op diagnosis made by a physician. Can be in progress note or H&P.
II. 2	Surgical consent is documented including risks, benefits & alternatives prior to procedure	TX.5.2 - 5.2.2	This applies to all OR procedures and any invasive procedure done in another area of the hospital. (Example: thoracentesis on Med-Surg, Swan-Ganz in ICU, adult LP in ER) For emergent procedures, there does not have to be a consent form, but there must be some type of note as to why. All 3 of the areas listed need to be completed on the surgical form.
II. 3	Pre-anesthesia assessment is documented	PE.1.8.1	This is the Anesthesia assessment form in the surgical section and must be done before any procedure.
II. 4	Patient is determined to be an appropriate candidate for anesthesia by a LIP	PE.1.8.2	This is the ASA score given during the Pre-anesthesia assessment. Can be by CRNAs or anesthesiologists.
II. 5	Pre-op plan for anesthesia is recorded	TX.2.1	"An anesthesia plan is developed to meet pt needs identified through preanesthesia assessment. Patients' anesthesia care needs are communicated among care providers." This is on the bottom of the Anesthesia Assessment form.

II. 6	Prior to the procedure, plan for nursing care is recorded	TX.5.3	This is the surgical nursing form completed before surgery and is in the surgical section.
II. 7	Prior to induction, patient is re-evaluated for anesthesia	PE.1.8.3	This is done by anesthesia and is found on the top, left-hand corner of the Intraoperative Anesthesia form.
II. 8	Patient's physiological status is measured & assessed <u>during</u> anesthesia	TX.2.3	The continuous monitoring by anesthesia of meds, IVs, vital signs, etc. during surgery. Found on backside of Anesthesia Assessment form.
II. 9	*<u>Post-operative</u>* monitoring (TX.5.4) and documentation (IM.7.3.3) of patients includes:	TX.5.4 IM.7.3.3	"The pt is monitored continuously during the postprocedure period." 10 – 18a is found on the PACU nursing form in the surgical section.
II. 10	Physiological status		Any physical signs/symptoms, VS monitored must be documented.
II. 11	Mental status		Changes in mental status must be documented. Can be a note or score.
II. 12	Intravenous fluids administered		All IV fluids must be documented.
II. 13	Medications administered		Any meds given must be documented.
II. 14	Blood and blood components		Any blood components given must be documented. Also, must have blood consent if blood given.
II. 15	Impairments and functional status		There should be documentation about function and any problems.
II. 16	Pain intensity and quality		"e.g., the character, frequency, location, and duration of pain, and responses to treatment"
II. 17	Unusual events: post-op complications / management		Ex: decreased BP, bleeding, etc.
II. 18	Patient is discharged from the post-anesthesia recovery area by a licensed independent practitioner or approved medical staff criteria	TX.2.4.1	This means the pt must meet the Aldretti score in the recovery room and/or be discharged by the Anesthesia provider. We usually use both. Find the scoring on the PACU recovery form on the front and who orders discharge in the nurse's note on the back.
II. 18a	Patient's status relative to post-anesthesia care discharge is documented in the medical record	IM.7.3.4.1	This is found on the front of the PACU recovery record and should be somewhere in the nursing note on the back.
II. 19	Operative report is documented immediately post-op	IM.7.3.2	Joint Commission states Op Reports must be dictated, transcribed, signed and in the chart within **6 hrs**. Since we cannot meet this, we have a transcription delay. The provider must enter the <u>operative progress note</u> **immediately** after the surgery, (like when the pt is in the recovery room). The time notation is **crucial** for this note.
II. 20	The operative report includes, as applicable:	IM.7.3.2	These are the items that must be found in the dictated Op Report and must also be in the handwritten Op progress note.
II. 21	Findings		What was found in the surgery or procedure
II. 22	Procedures		What the name of the procedure is
II. 23	Specimen(s) removed		Needs to say specimen removed and if sent to pathology.
II. 24	Post-op diagnosis		Must have post-op diagnosis, even if it is the same as the pre-op diagnosis.
II. 25	Name of surgeon/assistant		Person completing surgery or procedure and assistant.
II. 26	Operative report is authenticated by the surgeon	IM.7.3.2.1	Dictated Op Report and/or the Operative progress note must be signed by the operating surgeon (name & title).
II. 27	An operative progress note is entered *<u>immediately</u>* when there is a transcription delay	IM.7.3.2.2	Joint Commission states Op Reports must be dictated, transcribed, signed and in the chart within **6 hrs**. Since we cannot meet this, we have a transcription delay. The provider must enter the <u>operative progress note</u> **immediately** after the surgery, (like when the pt is in the recovery room). The time notation is **crucial** for this note.
RESTRAINT FOR ACUTE & SURGICAL CARE			
II. 28	Any use of restraint is pursuant to:	TX.7.5.3	
II. 29	An individual order		
II. 30	An approved protocol		
II. 31	At a minimum, a patient in restraint is monitored every 2 hrs	TX.7.5.4	
II. 32	Each episode of restraint use is documented in the patient's record	TX.5.5	
AMBULATORY CARE RECORDS			
II. 33	For patients receiving continuing ambulatory care services, there is a list of the following:	IM.7.4	
II. 34	Known significant medical diagnoses and conditions		

II. 35	Known significant operative and invasive procedures		
II. 36	Known adverse and allergic drug reactions		
II. 37	Medications known to be prescribed for and/or used by the patient		
II. 38	The list stated above is started by the 3rd visit	IM.7.4.1	
EMERGENCY			
II. 39	Provider codes are documented	IM.7-7.2	
II. 40	The time and means of the patient's arrival is documented	IM.7.5	
II. 41	Chief Complaint is documented	IM.7-7.2	
II. 42	Emergency care provided to the patient prior to arrival, if any, is documented	IM.7-7.2	
II. 43	Provider Subjective/Objective data documented	IM.7-7.2	
II. 44	Results of lab tests/x-rays ordered are documented	IM.7-7.2	
II. 45	Presence and/or absence of allergies is documented	IM.7-7.2	
II. 46	Consent for treatment is signed	IM.7.2	
II. 47	Patient's leaving AMA is documented	IM.7.5.1	
II. 48	The following are documented:	IM.7.5.2	
II. 49	Conclusions at the termination of treatment		
II. 50	Final disposition		
II. 51	Condition at discharge or transfer		
II. 52	Instructions for follow-up care		
II. 53	Title of provider is documented	IM.7.8	
II. 54	Emergency patient transfers to other organizations include:	CC.6	
II. 55	Reason for transfer		
II. 56	Stability of patient		
II. 57	Acceptance by the receiving organization		
II. 58	Responsibility during transfer		
II. 59	Relevant patient care & clinical information accompanies the patient	CC.7	
PEDIATRIC CARE			
II. 60	As appropriate, the assessment of infants, children and adolescents includes:	PE.5	Peds patients are: Newborns to age 12.
II. 61	Developmental age		Must be addressed on all peds pts.
II. 62	Length / height		Length on infants less than 2 yrs of age. Height after 2.
II. 63	Head circumference		For infants less than 12 months of age.
II. 64	Weight		Weights on all peds pts up to age 12.
II. 65	Immunization status		All peds pts must have this addressed.
II. 66	Consideration of the patient's education needs and daily activities		This includes teaching parents and shows they were involved.
II. 67	Family/guardian expectations for, and involvement in the assessment, initial treatment and continuing care of the patient are documented		Same as above. Parent or family member must be involved in care, teaching, planning, etc.