MASSACHUSETTS GENERAL HOSPITAL
PCS QUALITY, SAFETY & PRACTICE
CNS/PNS Informatics Group

Inpatient Chart Documentation Checklist:

Use to review basic elements of required documentation in each patient record. See: "NURSING PROCEDURE MANUAL/ DOCUMENTATION/ NURSING DOCUMENTATION: GUIDELINE FOR INPATIENT CARE UNITS" for more info

CRITERIA	Notes:
Advance directives/health care proxy • Completed Proxy or Documentation regarding discussion with patient about a HCP is present in record Hint: *Click on "CODE" or "MOLST" in header to view Advanced Care Planning* *For deeper dive/search: look at admission navigator question & look back in Media for "old LMR"*	Met __ Not Met__
Initial Nursing Assessment • Admission Navigator Overview and assessment is completed within 24 hours of admission Hint: *Look at Required Doc Go to summary→ search→ nursing admin summary for first value*	Met __ Not Met__
Allergies • Allergies are noted and up to date Hint: *Click on Allergies in Header. See history of "Mark as reviewed" completed by anyone (provider, RN, pharm) this encounter*	Met __ Not Met__
Plan of Care (POC) • The interdisciplinary plan of care and follow through is evident through summary activity including overview, patient story, and index tabs. The plan is: Individualized for the patient • Based on assessment and re-assessment of the patient's specific risk factors. • Interventions are appropriate • Progression of problems toward end goals is current (progressing, not progressing, resolved) • Discharge planning is started at admission, continues through daily education activity and plan of care documentation. • Documentation of education is completed every shift • Documentation of anticoag &/or diabetic teaching is documented Hint: *Start by going to patient story tab and reviewing patient's course* *From POC Activity, Look at Overview to provide summary (expected end dates, progressing/not progressing, and documentation within Education activity). May also use the Care Plan and Education Index* Report The entire record is the plan of care not just the nursing care plan.	Met __ Not Met__
Progress Note • Provides a synthesis of the patient's overall progress and plan • Focuses on problems that are not progressing in the Plan of Care (POC) • Documents assessments that need to be captured outside of flowsheet Hint: •Look for copy forward; utilize manual/ copy toggle •Look for unapproved abbreviations	Met __ Not Met__

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Transfer of care •Note should be a synthesis, the same as a progress note •Reviews the POC, problems should be up-to-date and resolved fno longer active •Review and update the Education activity Hint: *Summary→ overview→ scroll to bottom for ADT events* *Remind staff of how to/when to use transfer navigator* (e.g. to remember to check for and signed & held orders)	Met __ Not Met__
Flow Sheet Activity • Documentation is present when indicated for patient • VS, Intake/Output • Review all nursing orders • Any nursing assessments that are ordered on a timed frequency are documented as such (i.e. Q 2 hr. vascular checks, tele checks) • Safety risks including suicide, falls, pressure injury arealways documented on the Screening Flowsheet • Accurate documentation of items (e.g., infusions, restraints, Patient Observer) thatneed to be "stopped" to indicate that they have been discontinued Hint: *Consider using the following Index reports: Shift Assessment, Comprehensive Flowsheet, pain monitoring*	Met __ Not Met__
Fall Risk • Fall risk scale is completed on admission, daily, and with anychange in patient's risk factors (admission and shift req doc q24hr shift) • Interventions match risk factors Hint: *Consider discussing TIPS*	Met __ Not Met__
Skin Integrity • Braden scale is completed on admission, daily, and with anychange in patient's skin status • If skin integrity is impaired, stage of pressure injury anddescription are documented • PI care plan has appropriate interventions Hint: *Look to LDAs in the Assessment flowsheet, Mobility for repositioning? Plan of Care?* • Evaluation of interventions and patient's response are documented • Interventions match Braden scale risk factors	Met __ Not Met__
Pain Pt is screened for pain (intensity) on admission to ED or hospital… if not "0" or has had anesthesia or sedation in the past hour then assess pain including • Nature, intensity, and location • Reassessed and documented at least every 8 hours • Pain assessed before and reassessed (1hr) after administering analgesic: • When pain is identified as a problem: A pain treatment plan including problem, goals, interventions and individual response is noted in the Plan of Care	Met __ Not Met__

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• Review any pain medication in MAR: Look for Therapeutic duplication. Verify all PRN meds have distinct orders for use When more than one pain med ordered. Can staff explain which is used first and why? • Have staff trace documented time to corresponding pain score on the flow sheet. Verify that reassessment occurred. • If pain was persistent is there documentation of next steps? • Pain is reassessed and documented during PCA/PCEA analgesia per specific policy, respiratory rate, pain and sedation level within 1 hour after initiation of therapy and every 4 hours (PCA/PCEA flowsheet) Hint: *Look to Pain Index report: Summary→ Index tab*	
Blood Transfusion Staff involved in transfusion verification have completed MGH training Pre-transfusion: • Consent completed Administration: • Check consent • 2-RN ID check of patient ID and blood bank label, exp date, product ID on Bag matches blood bank label • ABO Rh compatibility donor and recipient Documentation includes: Temperature and vital signs should be obtained: • At the start of the transfusion; • During the transfusion if the infusion lasts longer than 30 minutes: • At the end of the transfusion. • Additional vital signs, if clinically indicated, are recorded in the patient's health record.	Met __ Not Met__
Consents Present and complete for surgery/procedures • All fields complete with signatures, dates and times • When interpreter is indicated, it is documented Hint: *If filed, they would be in Media tab. Otherwise in paper chart and not scanned in until discharged* *You may filter to "chemo and blood consents" quick button in media tab*	Met __ Not Met__
Timeout/Universal Protocol Completed for every invasive procedure that requires an informed consent • For bedside procedure: *Search and add "Time-out" flowsheet; review that flowsheet documentation completed or refer to Procedure note* • For OR procedure: *go to Chart Review→Encounter tab→ find Surgery encounter→ in OR Summary Index section, click on "Intraprocedural Summary"→ scroll to Pre-Incision documentation*	Met __ Not Met__

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Suicide • Screening completed at admission and if patient activity necessitates rescreen. • Patients who screen positively have psych assessment in notes that includes level of risk. Risk needs to be reassessed *daily* by psych. • Patients ordered for sitter have documentation of sitter (*in the Patient Observation section of "Daily Cares/Safety" flowsheet)* and creating a safe environment *(interventions in care plan)* • Staff should also speak to creating a safe environment using policy checklist, with verbal review with sitter of any remaining risks	Met __ Not Met__
Restraints • Order matches flow sheet (type) • All rows are completed once per shift • Attestation rows complete at end of shift • Restraints discontinued in flow sheet when order is discontinued • Make sure if restraints not needed, order is discontinued • *Note, based on etiology, most inpatient restraint orders should be for non-violent* • Refer to restraint guide for additional guidance	Met __ Not Met__
Critical Results Staff can describe the critical results process for their unit, including where the communication is documented • A "read back" of the critical result, using 2 patient identifiers, occurs between the clinician (RN, MD, NP, PA) receiving the result and lab • Critical result, it is communicated promptly to the Responding Clinician • The exact time of communication, mode of communication, name and title of the responding provider are documented in the Provider Notification section of the Assessment Flowsheet (ICUS exempt)	Met __ Not Met__
Other documentation for review Staff can show the following in the EHR: •Documentation that nurse-driven consults have been completed •Assessments by Provider-ordered consultants (e.g., PT, OT, SLP, Social Work) are documented •H&P from 30 days prior or within 24 hrs. of admission. •Monitored patients have parameters matching orders. Alarms answered promptly. •Flowsheets for titrated meds match orders (ICUs)	Met __ Not Met__