MASSACHUSETTS GENERAL HOSPITAL
PCS QUALITY & SAFETY

EED Regulatory Readiness Checklist (Inpatient Units)
Documentation Review

CRITERIA	MET	NOT MET	COMMENTS
☐ **Review your Nurse Manager Quality Dashboard**			
Confidentiality ☐ Staff can speak to how patient information is protected from unauthorized access			
Advance directives/health care proxy ☐ Available or documentation regarding a discussion about HCP is present in record			
Initial Nursing Assessment ☐ Admission Navigator overview and assessment is completed within 24 hours			
Allergies ☐ Accurate and up-to-date			
Consents ☐ Present and complete for surgery/procedures			
Timeout/Universal Protocol ☐ Completed for every invasive procedure that requires an informed consent			
Plan of Care (POC) ☐ Individualized for the patient ☐ Based on assessment and re-assessment of the patient's specific risk factors ☐ Progression of problems toward end goals is up-to-date (progressing, not progressing, resolved) ☐ Patients at risk for falls, pressure injury, suicide or self-harm have these problems documented in the POC activity and flowsheet ☐ Discharge planning is started with documentation			
Educational Activity includes patient and family: ☐ Preferred learning style is identified ☐ Education has been initiated that includes but is not limited to: ☐ Patient "Bill of Rights" ☐ Hand hygiene ☐ Respiratory Hygiene ☐ Medication and side effects ☐ Safe antibiotic use ☐ Safe anticoagulant use ☐ Isolation relevant to patient & family ☐ Discharge information / planning ☐ Understanding of educational content has been evaluated			

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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			
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should be a synthesis, the same as a progress note ☐ Reviews the POC, problems should be up-to-date and resolved if no longer active ☐ Review and update the Education activity			
Flow Sheet Activity Documentation is present when indicated for patient ☐ Timeout flowsheet (aka Universal Protocol) ☐ VS, Intake/Output ☐ Safety risks including suicide, self-harm, falls, pressure injury are always documented on the Screening Flowsheet ☐ Restrain flowsheet – documentation reflects the restraint in use for the patient *or* discontinued ☐ Provider notification of critical lab values is documented in the Assessment Flowsheet ☐ Blood Admin flowsheet – Transfusions are stopped and all VS are present ☐ Accurate documentation of items (e.g., infusions, restraints) that need to be "stopped" to indicate that they have been discontinued			
Fall Risk ☐ Fall risk scale is completed on admission, daily, and with any change in patient's risk factors ☐ Interventions match risk factors ☐ Evaluation of interventions and patient's response are documented ☐ Staff knows unit "falls with injury" rates / can locate falls quality data ☐ Staff describe unit-based strategies in place to eliminate falls			
Skin Integrity ☐ Braden scale is completed on admission, daily, and with any change in patient's skin status ☐ If skin integrity is impaired, stage of pressure injury and description are documented per standards ☐ Interventions are documented ☐ Evaluation of interventions and patient's response are documented ☐ Interventions match Braden scale risk factors ☐ Staff know unit pressure injury rates / can locate PI quality data ☐ Staff describe unit-based strategies in place to eliminate pressure			

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injuries			
Pain □ Pain assessed on admission to the hospital □ Pain is reassessed and documented at least every 8 hours □ Pain is assessed using an appropriate method, based on age and verbal ability When pain is identified as a problem: □ A pain treatment plan including stated problem, goals, interventions and individual response is noted in the Plan of Care □ Goals that are not progressing should also be documented in the progress note □ Pain is reassessed and documented after administering analgesic medications: a) 30 Minutes after a parenteral analgesic b) 60 minutes after an oral analgesic □ Pain is reassessed and documented during PCA/PCEA analgesia per specific policy □ Pain is assessed within an hour after invasive procedures that require procedural sedation or anesthesia. The assessment is documented using a navigator or flowsheet			
Blood Transfusion □ Staff involved in transfusion verification have completed MGH training Staff can describe: □ Practice related to transfusion □ Signs of blood transfusion reaction □ Procedure if there is suspicion of blood transfusion reaction Documentation includes: □ Two verification signatures and credentials □ Complete sets of Vital Signs (Temp, BP, HR, and RR) per policy □ Start and Stop of Transfusions on Blood Admin Flowsheet			
Critical Results Staff can describe the critical results process including where the communication is documented 1. A “read back” of the critical result, using 2 patient identifiers, occurs between the clinician (RN, MD, NP, PA) receiving the result and lab staff reporting 2. When the RN receives the critical result, it is communicated promptly to the responding provider 3. 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			

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Other documentation for review Staff can show the following in the EHR: ☐ Evidence of implementation of Provider orders ☐ The interdisciplinary plan of care and follow through is evident through summary activity including overview, patient story, and index tabs ☐ Documentation that nurse-driven consults have been completed ☐ Assessments by Provider-ordered consultants (e.g., PT, OT, SLP, Social Work) are documented ☐ Handover/transfer of care is careful and systematic (IPASS, transfer note) ☐ OR and Anesthesia notes are accessible in: chart review →encounter →anesthesia event/surgery ☐ No unapproved abbreviations are used			
Infection Control Staff can describe: ☐ Proper technique for use of Personal Protective Equipment (PPE) when caring for patients on isolation ☐ Measures to prevent central line-associated bloodstream infection (CLABSI) ☐ Measures to prevent urinary catheter-associated infections (CAUTI) ☐ Staff know unit CAUTI and CLABSI rates / can locate quality data ☐ Measures to prevent surgical site infection ☐ How staff is notified of need for patient to be placed on (Airbone, Airborne/Contact, Contact/Contact Plus, Droplet, or Enhanced) Isolation ☐ How patient is monitored regarding ongoing need for Isolation ☐ Documentation of negative / positive pressure checks when room is in use			