Medical Record Self-Assessment

*****SAMPLE DOCUMENT ONLY*****

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Medical Record Self-Assessment	Yes	No	Comments
1. Policies and procedures provide guidance for medical record documentation including but not limited to: • Assessment (e.g., admission, readmission, quarterly, change in condition) • Monitoring (e.g., neuro checks after a fall; 72-hour follow-up after an incident with injury) • Interventions (e.g., wound care, pain management, fall management) • Physician/Provider Communication • Physician Orders Including Verbal Orders • Family Communication • Resident/Family Teaching • Resident/Family Discharge Planning • Refused Medications or Treatments • Change in Condition Documentation • Documentation of an Injury, Incident/Accident and Suspected Abuse/Neglect • Medical and Behavioral Emergency Documentation • Care Plan/Service Plan Discussion and Attendance • Approved Abbreviations • Late Entries • Medical Record Corrections			

2. Medical record tools and templates reflect facility policies and procedures including documentation requirements			
3. Medical record tools and templates are reviewed annually as part of the annual policy and procedure review process			
4. If incident reports are entered as part of the electronic medical record software (e.g., PointClickCare) there are defined policies/procedures/protocols to ensure that incident reports are not considered part of the medical record. Completion of an incident report is not mentioned in the medical record.			
5. If paper medical records are used, policy and procedures address: • Structured communication processes (e.g., DAR, SBAR, SOAP notes) • Use of templates, data sheets (e.g., ADLs) and progress notes • Completion of assessments (e.g., fall risk, skin injury risk, elopement risk, smoking safety assessment, medication self-administration) • Professional entries (e.g., grammar, spelling) • Accepting and signing-off physician orders • Legibility • Notes are dated, timed and signed • Correction of errors • Approved abbreviations • Late entries			
6. If electronic medical records are used, policy and procedures address: • HIPAA privacy and security requirements • System confidentiality and security (e.g., passwords, authorized access, unauthorized access audit reviews, screen protection from unauthorized viewing) • Off-site access of medical records by providers – responsibilities for confidentiality and system security should be acknowledged in writing • Structured communication processes (e.g., DAR, SBAR, SOAP notes) • Use of templates, data sheets (e.g., ADLs) and progress notes • Completion of assessments (e.g., e.g., fall risk, skin injury risk, elopement risk, smoking safety assessment, medication self-administration) • Copy and paste feature usage, if allowed (not recommended) • Correction of errors			

*Note – This list is not intended to be exhaustive, and modification is recommended based on facility services and policies.

• Approved abbreviations • Late entries • Professional entries (e.g., grammar, spelling) • Accepting and signing-off physician orders • Hybrid records - combination paper and electronic • Secondary records – (e.g., records from other facilities, photos, electronic communication related to resident care)			
7. Policies and procedures address medical record storage, data integrity and security in compliance with licensure, regulatory and state and federal laws.			
8. Policies and procedures address release of medical record information to residents, family members, attorneys, and other persons/entities, including requirements for a HIPAA-compliant, signed release form from the resident or designated authorized party.			
9. Medical record documentation policies and procedures reflect current practice. If purchased or obtained from another organization, the policies are modified to reflect facility practice.			
10. Quality metrics are established to concurrently review and measure documentation practices including but not limited to new admissions, readmissions, change in condition, accident or injury, behavioral events, resident and family communication and teaching, discharge planning and instructions, resident refusal of medications or treatments, medication response, and physician/provider communication.			
11. New employee onboarding and orientation includes a review of key policies and procedures related to documentation in the medical record.			
12. Annual competency validation includes a review of key policies and procedures related to documentation in the medical record.			
13. Medical records are reviewed post-incident/accident to ensure that a clinically pertinent assessment, interventions, and communications were documented in the medical record. The review would ideally be completed the same shift by a charge nurse or supervisor and with the leadership/management team at the next morning meeting/Stand-Up Meeting.			

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14. Follow-up documentation requirements are prompted by the electronic medical record software and/or other formal written and verbal communication processes (e.g., 24-hour report, shift report).			
15. The Quality Process includes a review of any potential gaps between policy/procedure and actual practice. Gaps create potential regulatory and legal exposure for the organization.			

Medical Record Documentation (Following Facility Policy and Procedure)	Actual Practice	Practice When an Event Occurs	Regulations	"The Gap"

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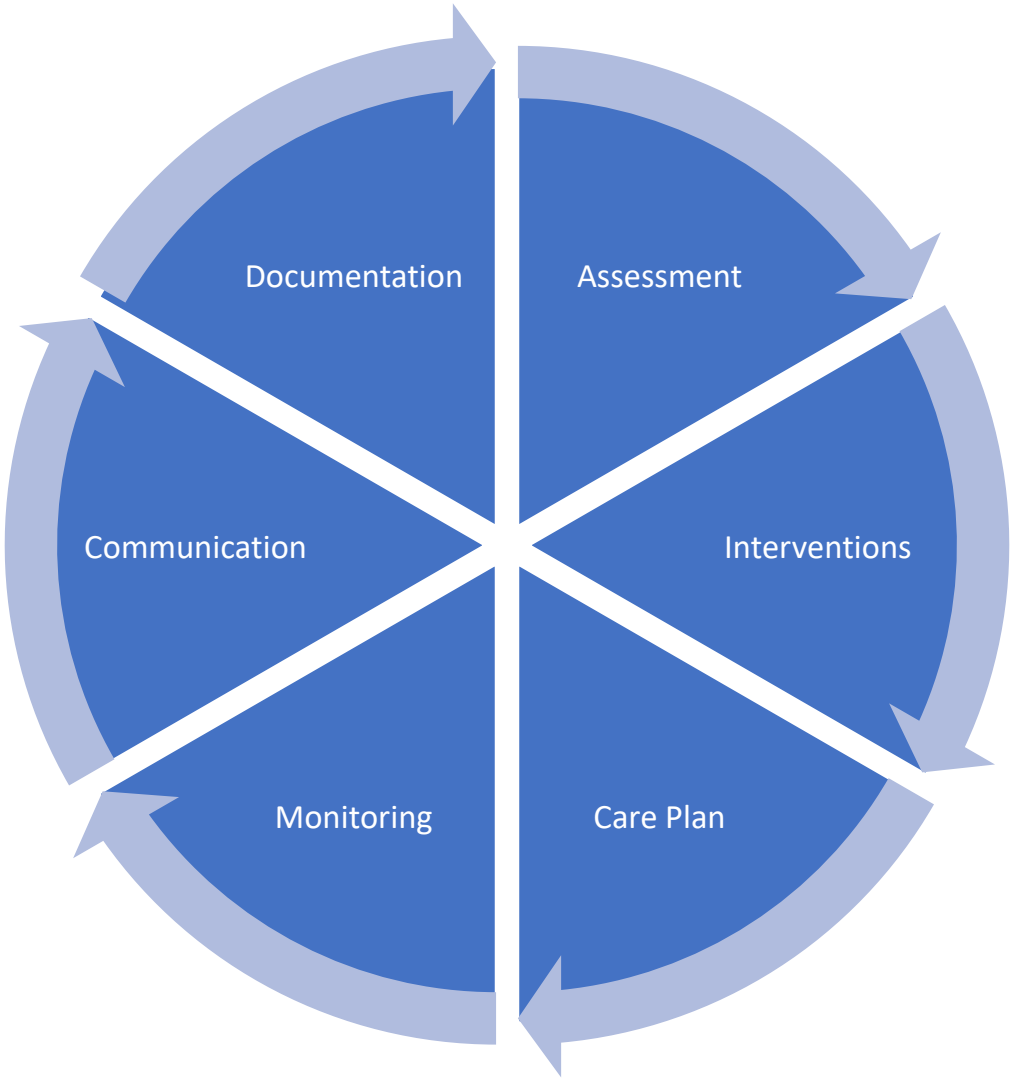
Clinically Pertinent Documentation Includes the Resident-Center Care Cycle:



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