Morning Clinical Meeting:
Medical Record and Care Plan Review

As a partner to senior living and long-term care organizations, Marsh McLennan Agency promotes the use of best-practices in resident care. Holding a morning clinical meeting can help control claims, streamline communication, ensure long-term success for teams and residents. Below is a sample check list for use during medical record and care plan reviews.

New Admission/Readmission (Review of Medical Record and Care Plan)

- ☐ Resident safety risks identified (e.g., fall risk, skin injury risk, elopement risk, behavioral risk, safety compliance risk – e.g., ability and compliance with using the call light)
- ☐ Resident clinical status – including new and pending orders, acute conditions
- ☐ Interventions in place that support clinical status and identified resident risks
- ☐ Care Plan in place with realistic goals (minimize, manage, reduce the risk of falls, skin injuries, elopement, etc)
- ☐ Actions needed for the first 48/72 hour Care Plan
- ☐ Status of provider and family communication
- ☐ Documented resident and family teaching

Incident with Injury (Review of Medical Record and Care Plan)

- ☐ Brief, objective documentation of the incident
- ☐ Clinically pertinent documentation of resident condition and description of injury
- ☐ Documentation of provider communication
- ☐ Documentation of family notification
- ☐ New physician/provider orders initiated
- ☐ Incident report completed
- ☐ Incident investigation started
- ☐ Interventions in place that support clinical status and identified resident risks
- ☐ Care Plan in place with realistic goals (minimize, manage, reduce the risk of falls, skin injuries, elopement, etc)
- ☐ 72-hour charting alerts in place

Change in Condition (Review of Medical Record and Care Plan)

- ☐ Clinically pertinent documentation of resident condition (structured communication is recommended, e.g., SBAR)
- ☐ Documentation of provider communication
- ☐ Documentation of family notification
- ☐ New provider/physician orders initiated
- ☐ Interventions in place that support clinical status and identified resident risks
- ☐ Care Plan in place with realistic goals (minimize, manage, reduce the risk of falls, skin injuries, elopement, etc)
- ☐ 72-hour charting alerts in place

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