Gateway Health

MEDICAL RECORD REVIEW STANDARDS
SKILLED NURSING FACILITY

1. MEMBER ID*	Each page in the record contains member name of member ID number.
2. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID*	All entries, included dictation, are signed (electronically) or initialed by the licensed professional (as appropriate). NA notes are to be cosigned by the supervising professional. All verbal orders are cosigned by the physician.
4. ENTRY DATA*	All entries are dated.
5. LEGIBILITY*	The record is legible to someone other than the originator.
6. MEDICATION LIST*	Medication listed must be up-to-date.
7. MEDICATIONS ADMINISTRATION*	All administered medications are recorded when given. Initials have corresponding complete signature.
8. PRESCRIBED MEDICATION*	Prescribed medications, including dosage and frequency that the member takes, are documented on a medication list.
9. PRN MEDICATIONS*	Documentation of effectiveness of PRN medications is noted.
10. ANNUAL MEDICATION REVIEW*	At minimum, medications are reviewed annually.
11. ALLERGIES*	Presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart after one year of age.
12. NURSING HISTORY*	Includes serious injuries, operations and illnesses, and secondary conditions and any other disorders that impact on the member's care. Documentation must include member's current condition, mental status, functional status and reason for admission to the skilled nursing facility.
13. PAST MEDICAL HISTORY*	Documentation in the record includes the physician's history, member's physical exam, and the current need for care.
14. TOBACCO USE*	Use/nonuse of tobacco products is documented on members age 11 and older. This includes tobacco, chew, pipe and/or snuff.
15. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
16. WORKING DIAGNOSIS	There is a clearly documented diagnosis related to services being rendered, whether from the hospital from which the members was discharged or from the physician referring the member directly to the skilled nursing facility.
17. DIETARY RESTRICTIONS	Documentation of nutritional assessment is required.
18. SPECIFIC CARE AND SERVICES*	Documentation includes skilled observations/assessment, intervention, treatments and updated orders.
19. INTERDISCIPLINARY TEAM	There is documentation of an interdisciplinary team approach to care.
20. SPECIFIC PLAN OF CARE*	Physician orders must be in writing and present in the record. Documentation of a completed medical plan developed in collaboration with the member. Plan of care must include any functional limitations.
21. FUNCTIONAL ASSESSMENT	Documentation of a functional assessment annually at a minimum.
22. DISCHARGE PLANNING*	There is documentation of discharge planning and a discharge summary within 30 days of discharge.

***Indicates Critical Factors**

Gateway Health

MEDICAL RECORD REVIEW STANDARDS
SKILLED NURSING FACILITY

23. SOCIAL SERVICE	There is evidence of social service intervention or documentation by an appropriate staff member with suitable training or experience, and who is responsible for making integration arrangements so the member can return back into the community, transfer to a home, or transfer to another facility where appropriate level of care is available.
24. CONTINUITY & COORDINATION OF CARE*	There is documentation of relevant information to the PCP/ordering physician on a regular basis, and at discharge.
25. PAIN ASSESSMENT	There is comprehensive pain assessment annually.
26. COMMUNICATION WITH THE PCP	If the PCP is not the admitting physician, there is documentation of communication with the PCP on record prior to discharge.
27. DISCHARGE SUMMARY	There is evidence of discharge summary to the PCP.
28. DNR	There is documentation of the members' wishes for DNR status.
29. MEDICALLY APPROPRIATE CARE*	There will be no evidence that the member was placed at inappropriate risk by a diagnostic or therapeutic modality.
30. OBSERVATIONS	There is a notation on every tour of duty on critically/acutely ill members, and every 30 days on other members.
31. NUTRITIONAL SERVICES*	There is documentation of nutritional needs and responses at least quarterly.
32. ADVANCE DIRECTIVE	There is annual documentation of whether the member has executed an advance directive (ages 21 and older). If "yes," a copy must be included in the medical record. Advance care plans include advance directive, actionable medical orders, living wills and surrogate decision maker.

***Indicates Critical Factors**