MEDICAL RECORD NUMBER: ___________________
DATE OF DISCHARGE: __________________________

Closed Medical Record Review Form (To Be Used During the Medical Record Interview for Data Collection)			Standard is Applicable to the Record Being Reviewed		Documentation of Standard Requirement is Present	
	Standard No.	**General Items**	**Yes**	**No**	**Yes**	**No**
1. /	IM.7.2	Evidence of known Advance Directives.				
2. /		Evidence of Informed consent.				
3./	IM.7.7	Verbal orders are authenticated within time frame when required by law or regulation .				
4. /	IM.7.8	Are all entries dated and, when necessary, authenticated.				
5.		Entries made by house staff are countersigned per policy specified in medical staff rules and regulations.				
6./	TX.1	Are treatment plans documented.				
7./	PE.1.6.1	Were the following completed within 24 hours of admission as an In-Patient:				
8./		History and physical examination.				
9./		Nursing Assessment.				
	Standard No.	**Education**	**Yes**	**No**	**Yes**	**No**
10. /	PF.1	Are patient's learning needs, abilities, preferences, and readiness to learn accessed?				
11.	PF.1.1	The assessment considers:				
12.		Cultural beliefs;				
13.		Religious Beliefs;				
14.		Barriers to learning (for example, emotional, physical, cognitive).				
15.	PF.1.2	When called for by the age of the patient and the length of stay, school-age children are given the opportunity to continue their schooling.				
16.	PF.1.3	When appropriate, the patient is educated about the safe and effective use of medication.				
17.	PF. 1.4	When appropriate, the patient is education about the safe and effective use of medical equipment.				
18.	PF.1.5	When appropriate, the patient is education about diet and nutrition, including potential drug-food interactions.				
19.	PF.1.6	When appropriate, the patient is education about rehabilitation techniques.				
20.	PF.1.7	When appropriate, the patient is education about available community resources.				
21.	PF.1.10	When appropriate, the patient is education regarding personal hygiene and grooming.				
22.	PF.4.2	Was the educational process interdisciplinary as appropriate to the care plan.				

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	Standard No.	**Assessment**	**Yes**	**No**	**Yes**	**No**
23. /	PE.1	The following are assessed for each patient:				
24. /		Physical Status;				
25. /		Psychological Status; and				
26. /		Social Status.				
27.	PE.1.2	When warranted by the patient's need, nutritional status is assessed.				
28.	PE.1.3	When warranted by the patient's need, functional status is assessed.				
29.	PE.1.3.1	A functional assessment is performed for each patient referred for rehabilitation services.				
30. /	PE.1.5	Need for discharge planning is determined.				
31.	TX.3.9	Monitoring of a medication's effect on the patient includes an assessment based on collective observations, including the patient's own perceptions of its effect.				
	Standard No.	**Inpatient Psychiatric**	**Yes**	**No**	**Yes**	**No**
32.	PE.6	Does the evaluation for a psychiatric inpatient include the following:				
33.		History of emotional, behavioral, and substance abuse problems, their co-occurrence, and treatment;				
34.		Current emotional and behavioral functioning;				
35.		Maladaptive or problem behaviors;				
36.		Psychosocial assessment; and				
37.		When appropriate, legal assessment.				
38.	TX.7.1.3.1.7	If applicable, when emergency use of restraint or seclusion is ordered, a licensed independent practitioner is called within one hour to authorize continued use.				
39.	TX.7.1.3.1.8	If applicable, an order for restraint or seclusion is limited to four hours for adults, two hours for children and adolescents ages 9 to 17, and one hour for patients under age 9.				
	Standard No.	**Reassessment**	**Yes**	**No**	**Yes**	**No**
40. /	PE.2.1	Each patient is reassessed:				
41.	PE.2.2	To determine the patient's response to care; and				
42.	PE.2.3	When there is significant change in the patient's condition.				
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	Standard No.	Reassessment (Continued)	Yes	No	Yes	No
43.	PE.3	Have staff members integrated information from various assessments of the patient to identify and assign priorities to care needs?				
44.	PE.3.1	Were care decisions based on the identified patient needs and care priorities?				
	Standard No.	**Operative and Invasive Procedures**	**Yes**	**No**	**Yes**	**No**
45.	PE.1.7	Pre-op history and physical and diagnosis is recorded.				
46.	PE.1.7.1	Pre-anesthesia assessment (for example, risk, ASA) is documented.				
47.	TX.2.1	Pre-op plan for anesthesia is recorded.				
48.	PE.1.7.2	Patient is determined to be an appropriate anesthesia candidate.				
49.		Determination is made by a licensed independent practitioner.				
50.	TX.5.3	Prior to procedure, plan for nursing care is recorded.				
51.	PE.1.7.3	Prior to induction, the patient is re-evaluated for anesthesia.				
52.	TX.2.3	The patient's physiological status is measured and assessed during anesthesia.				
53.	TX.5.4	Post-operative monitoring of patient includes:				
54.		Physiological status;				
55.		Mental status;				
56.		Intravenous fluids administered;				
57.		Drugs administered;				
58.		Blood and blood components;				
59.		Impairments and functional status; and				
60.		Unusual events: post-operative complications or management.				
61.	TX.2.4.1	Patient is discharged from the post-anesthesia recovery area by a licensed independent practitioner; or				
62.		Patient is discharged from the post-anesthesia recovery area by meeting medical staff criteria.				
63.	IM.7.3.2	The operative report is documented immediately post-op.				
64.		The operative report includes, as applicable:				
		Findings;				
		Procedures;				

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	Standard No.	Operative Report (continued)	Yes	No	Yes	No
		Specimen removed;				
		Post-op diagnosis; and				
		Name of surgeon or assistant.				
70.	IM.7.3.2.1	Operative report is authenticated by the surgeon.				
71.	IM.7.3.2.2	A progress note about the operation is entered immediately when there is a transcription delay.				
		Restraint or Seclusion				
72.	TX.7.1.3.1.7	Each episode of restraint or seclusion is ordered by a licensed independent practitioner.				
73.	TX.7.1.3.1.8	Each episode of restraint or seclusion has specific time limits documented.				
74.	TX.7.1.3.2	Each episode of restraint or seclusion includes:				
		Clinical justification for use;				
75.		Orders that meet the requirements described in hospital policy;				
76.		Measures taken to protect the rights, dignity, and well-being of the patient including monitoring, reassessment, and attention to patient needs.				
		Ambulatory Care Records				
77.	IM.7.4	For patients receiving continuing ambulatory care services, the following are listed:				
78.		Known significant medical diagnoses and conditions;				
79.		Known significant operative and invasive procedures;				
80.		Known adverse and allergic drug reactions;				
81.		Medications known to be prescribed for or used by the patient.				
82.	IM.7.4.1	The list stated previously is started by the third visit.				
		Emergency				
83.	IM.7.2	Emergency care provided to the patient prior to arrival, if any, is documented.				
84.	IM.7.5.2	Conclusions at the termination of treatment are documented, including:				
		Final Disposition;				

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	Standard No.	**Emergency (Continued)**	**Yes**	**No**	**Yes**	**No**
		Condition at discharge;				

		Any instructions for follow-up care.				
88.	CC.6	Emergency patient transfers to other organizations include:				
89.		Reason for Transfer;				
90.		Stability of patient;				
91.		Acceptance by the receiving organization;				
92.		Responsibility during transfer.				
93.	CC.7	Relevant patient information accompanies the patient.				
		Pediatric Care Record				
94.	PE.5	As appropriate, the assessment of infants, children, and adolescents includes:				
95.		Developmental age;				
96.		Length and height;				
97.		Head circumference;				
98.		Weight;				
99.		Consideration of the patient’s education needs and daily activities;				
100.		Immunization status; and				
101.		Family or guardian expectations for and involvement in the assessment, initial treatment, and continuing care of the patient are documented.				
		Research, Clinical Trials, and Experimentation				
102.		All patients asked to participate in a research project are given:				
103.	RI.1.2.1.1	A description of benefits to be expected;				
104.	RI.1.2.1.2	A description of potential discomforts and risks;				
105.	RI.1.2.1.3	A description of alternative services;				
106.	RI.1.2.1.4	A full explanation of procedures to be followed; and				
107.	RI.1.2.1.5	An assurance of right to refuse to participate.				
108.	RI.3.1.(Scored at IM. 7.2)	All consent forms related to research, experimentation, or clinical trials:				

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	Standard No.	**Research, Clinical Trials, and Experimentation (Continued)**	**Yes**	**No**	**Yes**	**No**
109.		Indicate name of person who supplied prospective participant with information.				
110.		Indicate date form was signed; and				

111.		Address the participant's right to privacy;				
112.		Confidentiality;				
113.		Safety.				