Chart Reviews for Survey

A Pharmacist view of ways to identify and avoid documentation issues commonly seen

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Chart Reviews for Survey

- Why do we do chart review?
  - To make sure documentation is consistent
  - To determine if anything is missing
  - Examining any mistakes which may have occurred
  - Checking for controlled substance documentation

Controlled Substance Documentation

- Nursing notes vs. Anesthesia Logs vs. countdown sheets
  - Look at patient's chart
  - Record all controlled substances administered in nursing notes
    - Pre-op
    - Intra-op
    - PACU
  - Match any Nursing notes to Anesthesia records
  - Match Anesthesia and Nursing notes to countdown sheets

Controlled Substance Documentation

- Waste
  - Missing second signature when documenting waste
  - Never see any waste recorded
- Consistent Documentation
  - 100 mcg Fentanyl on countdown sheet vs 50 mcg in notes
  - 7 vials of Versed dispensed for the day, but 8 patients administered Versed

Consistent Documentation

- Pre-op ABX
  - Ancef/Clindamycin/Vancomycin
  - Must be given within 1 hour of the first incision; otherwise it must be repeated prior to the surgery
  - Vancomycin/Quinolones must be within 2 hours of the first incision (due to its longer half-life)
- Documentation of properly executed informed patient consent

History and Physical

- The H&P should specifically indicate that the patient is cleared for surgery in an ambulatory setting.
- It is not acceptable to conduct the H&P after the patient has been prepped and brought into the operating or procedure room, since the purpose of the H&P is to determine if the surgery is appropriate *before the surgery*
- H&P must be updated upon admission (statement “no major changes since the H&P was conduced if not done on the same day)
- Must be done within 30 days of the surgery
- Can be used more than once (ex: H&P 5/1, 1st surgery 5/4, and 2nd surgery 5/18)
- Must be labeled as a History and Physical

Pre-Surgical Assessment

- *Assessment for the risk of the procedure and anesthesia*
  - Each ASC patient upon admission to the ASC must have a pre-surgical assessment.
  - If the H&P is performed on the day of the surgical procedure in the ASC, the H&P assessment may be combined with some, but not all, of the elements of the pre-surgical assessments.
  - Should include other conditions which may affect the surgery (ex – allergies)

H&P vs. Pre-Surgical Assessment

a. The requirement for a physician to examine the patient immediately before surgery is not to be confused with the separate requirement at 42 CFR 416.52(a)(1) for a history *and* physical assessment performed by a physician, although it is expected that the physician will review the materials from such pre-admission examination as part of the evaluation.

b. In those cases, however, where the comprehensive history and physical assessment is performed in the ASC on the same day as the surgical procedure, the assessment of the patient's procedure/anesthesia risk must be conducted separately from the history and physical, including any update assessment incorporated into that history and physical.

Allergies

a. Consistency
b. Reactions –Should be written next to the allergy
c. Documentation of drug allergies in the medical record and on its outside front cover and documentation of other allergies in the medical record;

Post-Op

- Assessment of the patient
- Recovery from anesthesia
- A record of medications administered. After each drug administration, the following shall be documented by the nurse who administered the drug:
  - name and strength of the drug
  - date and time of administration
  - dosage administered
  - method of administration
  - signature of the nurse who administered the drug.
- Sequencing as needed medications

Signatures

- The medical record shall be completed within the time frame specified in the medical records policies and procedures, which shall be no longer than 30 days from the last treatment or discharge.
- All orders for patient care shall be prescribed in writing and signed and dated by the prescriber, in accordance with the laws of the State of New Jersey. All orders, including verbal orders, shall be verified or countersigned in writing within seven days.

Discharge

- Medication Reconciliation
- Discharge order signed by the operating physician
- Discharge notes and plan
- Include documentation of post-surgical needs
- Discharge Summary Sheet
  - Should be 1 page
  - Patient's name, address
  - Dates of admission and discharge
  - Summary of the treatment and medication rendered during the patient's stay