Getting Started with Validation of Selected AHRQ Quality Indicators

(Version 1.0 4/20/2007)

Getting Started   Table of Contents

Table of Contents....2
Getting Started....3
Face Sheet....3
Consent Forms....3
Discharge Summary....3
Emergency Medical System (EMS or EMSS) Records....4
Emergency Department (ED) Records....4
Admission History and Physical....4
Consultation Reports.... 5
Patient Progress Notes....5
Orders....5
Nursing Admission Assessment....5
Nursing Records.... 5
Care Plan.... 6
Interdisciplinary Care Records.... 6
Diagnostic Results Section.... 6
Operative Reports and Procedure Notes.... 6
Medication Administration Record.... 7

Start by reading the admission history and physical, the physician progress notes, the surgeon’s notes, nursing notes and the discharge summary. Note the location of key records (e.g., patient progress notes, nursing notes, radiology reports, medication administration records, etc). You may wish to flag “key” statements with” post-it notes” in order to facilitate subsequent retrieval of information.

Hospitals across the country generally collect similar types of information, largely in part to the many professional and regulatory standards that guide present-day care. To assist with data element location, an outline of the most common chart groupings and/or forms is listed below. Documents in parentheses are not necessarily synonyms, but represent other documents or parts of the medical record that may contain similar information.

Face Sheet (admitting form, registration form, admission data sheet or form): This form or section of the chart contains demographic information such as the patient's name, medical record number, social security number, address, contact information, date of birth, gender, race, primary physician, admission date, discharge date, and health insurance status. Patient identifiers listed on the face sheet link the different hospital and billing systems. Discharge ICD-9CM codes are often found here.

Consent Forms: Before being treated, a patient must sign a consent form for "routine" and "nonroutine care." Routine care consists of standard, low-risk procedures, such as the administration of medications, phlebotomy, the insertion of intravenous lines, and routine diagnostic procedures performed as part of usual hospital care. Nonroutine care consists of surgical procedures, diagnostic, and/or therapeutic interventions that have a higher inherent risk and requires an independent consent for treatment.

Discharge Summary (final summary, transfer summary, discharge note, dictated discharge summary, physician's discharge summary): This is a summary of the patient's hospital experience completed at the time of discharge completed by the attending physician or designee. All live discharges must have a discharge summary. A complete discharge summary (per Joint Commission Accreditation of Health Care Organizations) includes: the chief complaint, history of the present illness, significant objective findings including pertinent results from laboratory tests, radiological exams, and pathological studies, treatment rendered, all relevant diagnoses, condition on discharge, patient and family instructions, and signature of the attending physician. Discharge summaries written by physician extenders, residents, and other staff should be co-signed by an attending physician.

Other health care professionals and physician consultants may have service specific discharge summaries that are completed at the time of discharge or when their respective services are no longer required. In addition to the physician's discharge summary, most hospitals may have standardized transfer sheets and/or discharge forms completed at the time of discharge, often taking the form of a checklist, that focus on specific discharge needs and instructions.

Emergency Medical System (EMS or EMSS) Records (pre-hospital, run sheet, field records, or ambulance call records): This is a summary of the care, evaluation, and treatment provided to the patient prior to entry into the hospital

system. These records are completed by EMS staff. Some hospitals include a summary of the EMS record in the first section of the Emergency Department Flowsheet. These records may be filed in various sections of the medical record such as outpatient, transfer records , emergency department, miscellaneous, or other such sections of the chart.

Emergency Department (ED) Records: This section of the chart typically contains an Emergency Department Flowsheet or record (e.g., Nursing Flowsheet, Trauma Flowsheet, or Emergency Care Record). The emergency department record captures the patient's interaction with the emergency department. The emergency department record contains all pertinent assessments, treatments, diagnostic tests, and outcomes from ED admission through ED discharge. Some hospitals include medications on the flowsheet, while others have a separate medication administration record. Because of the increasing complexity of ED care, additional care records may be used to address specific needs such as a neuro flowsheet for a patient with a head injury or a ventilator flow sheet for mechanically ventilated patient. ED physicians usually have their own specific flowsheet or treatment record where they document their orders, history and physical, ongoing assessment and plan of care. ED physicians also complete a discharge summary describing the ED event.

Admission History and Physical (admission transfer summary, admission note, history and physical (H&P), physician history and physical or preoperative history): The admission history and physical is written by the admitting physician on the day of admission. It is required to be present prior to surgery and within 24-hours of admission. The history and physical as well as progress notes completed by physician extenders or medical students on-behalf of the attending physician must be co-signed to be valid. Standard format includes: chief complaint (reason for admission), history of present illness, prior medical history, family history, social history (including alcohol, smoking and illicit drug use), physical exam, laboratory test results, diagnostic impressions, working diagnosis, and the medical plan of care. The history and physical may be completed up to 30-days prior for an elective surgery.

Consultation Reports (consultation notes): Attending physicians may ask other specialists to provide expert opinion or to provide specialized care. Most consulting specialists document their initial assessment in the form of a consultation report, much like a targeted admitting history and physical, although some use specialized forms. Consultants may also document in the patient progress notes or interdisciplinary portion of the chart.

Patient Progress Notes (physician progress notes, physician notes, progress notes and postoperative notes): The progress note reflect a daily or contemporaneous accounting of the patient's progress. Some hospitals have special formats for documentation such as SOAP (subjective findings, objective

findings, assessment and plan). Historically, progress notes have been completed primarily by physician(s), however other disciplines are increasingly documenting in this section of the chart. Sometimes special records such as a code blue report are filed in the patient progress note section.

Orders (physician orders, physician order sheets, medical orders, treatment plan, order sheets, computerized physician order entry, computer provider order entry) and ORDER SETS (standardized order sets): The term physician order set was originally used to describe the paper based system allowing physicians to communicate their clinical orders for a patient such as those for medications, diagnostic studies, therapeutic procedures, and monitoring activities. Today physicians are not the only clinicians entering orders, especially with the advent of the electronic medical record. Other health care professionals may order treatments and alter the plan of care within their scope of practice. Both paper and electronic based order sets contain additional important information about the patient such as the admitting diagnosis, the patient's condition on admission and allergy status. For orders to be "active", they must be signed by the appropriate clinician. All verbal and telephone orders must have a read back process and must to co-signed by a physician within 24-hours. An electronic signature will suffice for electronic databases. Most hospitals have developed standardized orders set for common admitting diagnoses and to a lesser extent standardized discharge order sets. Orders regarding pulmonary resuscitation are usually found on the interdisciplinary code blue report.

Nursing Admission Assessment (or nursing admission database, nursing admission note, nursing history and physical, initial assessment, initial database assessment): This form is completed by the nursing staff upon a patient's admission to an assigned hospital unit. It includes a description of the patient's condition, history, medications, allergies, health behaviors, systems review including a functional and psychosocial assessment, patient problem list, as well as community, health management, educational and teaching needs. Vital signs, height, and weight are part of a complete admission assessment.

Nursing Records (nursing notes, observation records, special care unit notes or flow sheets): Nursing notes constitute a large portion of the medical record. This includes items such as vital signs, intake and output, daily weights, tests performed, ongoing assessments, safety measures, comfort measures, and such. Flow sheets usually contain a section for a short narrative nursing note. With the advent of the electronic medical record, the amount of free text is becoming increasing less. Nurses may also document their narrative nursing note on the patient progress notes, depending on the medical system. There is considerable variability in how nursing records are constructed within hospital systems. However, most hospitals have some type of nursing care plan, teaching record, and numerous individual records targeting specific needs (e.g., chemotherapy flow sheet , diabetic record, restraint record, etc). Nursing and

medical diagnoses differ, although complimentary, they must not be confused or interchanged.

Care Plan (critical pathway, clinical pathway care path , nursing care plan, patient care plan, and interdisciplinary plan of care): Each patient must have a care plan with evidence of interdisciplinary participation that targets key treatment steps and outcomes. Most hospitals have standardized care plans for their most common medical diagnoses.

Interdisciplinary Care Records(individual department record or flow sheets , such as respiratory therapy flow sheet, discharge planning care record, social services record, and physical therapy treatment record): Many individual hospital departments have their own flow sheets and/or forms used to communicate their assessments, treatment plans, and care rendered.

Diagnostic Results Section (Laboratory or radiology): Laboratory and pathology reports are the recordings of clinical data that can be obtained from clinical laboratories. The majority of hospitals have automated their laboratory results into daily and weekly abstracts. This section typically contains all serology, hematology (and/or coagulation), pathology (autopsy), toxicology, and microbiology (bacteriology) reports. Blood gas results may be found here or under respiratory care. Autopsy reports (postmortem examination) not performed by the hospital staff but by the Medical Examiner of the municipality or by an independent pathologist not affiliated with the hospital hired by family may be not be included in the medical record.

Radiology reports (such as chest x-rays, CT, MRI, ultrasound and other “imaging” reports) may be contained here or under their own section. The radiology or imaging report describes the findings on a particular imaging study. The report is typically dictated, typed and added to the chart after 12-72 hours. In addition to the dictated report, a brief or cursory note (“wet” read) may be included for specific tests or in an emergent situation.

Operative Reports and Procedure Notes: There are several key surgical forms. The first is the preoperative care record or checklist that includes verification of vital tasks required prior to an operative procedure such as the presence of a signed consent, NPO status, patient verification, surgical preparation activities, allergies, location of valuables, and patient education. The final stop and check to ensure the right patient and procedure may be included on this form. The surgeon completes a detailed operative or procedure note report that includes the names of physicians participating in the procedure, procedure name, preoperative diagnosis, type of anesthesia used (if any), patient positioning, patient preparation, step-by-step description of the operative procedure, operative mishaps and corrective actions, miscellaneous operative information (e.g., estimated blood loss, tourniquet time, sponge count, etc.), condition after procedure, postoperative diagnoses, dictation date, and surgeon’s

signature. A note describing a simple procedure will contain less detail and be considerably shorter.

Each invasive medical invention from a radiological procedure to brain surgery requires a procedure or operative note. The physician who performs the procedure or operation is responsible for either write or immediately dictating a note after each procedure. In academic institutions, an intern or resident who assisted in the procedure may be delegated with the task of completing the note. In this instance, the person who actually performed the procedure and those that assisted should be named in the report. Each operation and/or procedure requires a separate report except for procedures performed as a bundle.

Anesthesia documentation should include a pre-anesthesia evaluation, intraoperative/procedural anesthesia evaluation note (time-based record of events), and a post-anesthesia evaluation. The intra-operative or procedural anesthesia evaluation starts immediately prior to the initiation of the anesthetic procedure. It is a time based note that includes ongoing assessments of the patient, equipment checks, medication administrated, fluid administration, technique(s) used, problems/unusual events (such as difficulty with endotracheal intubation, insertion of a central venous or arterial line, sudden drops in blood pressure or oxygenation, etc.), and the status of the patient at the conclusion of anesthesia. Often the names of the surgical team are included on this record. The post-anesthesia evaluation includes any unusual events (post-procedural or post-anesthesia complications) and discharge from the post-anesthesia care unit.

Many hospitals have a combination preoperative and post-operative care record or flow-sheet. Depending on the type of procedure, some hospitals have abbreviated forms for procedures performed under conscious sedation. Besides post-operative recovery, PACUs are used for various conscious sedation related procedures (e.g., epidural blocks, elective cardioversion, post-angio procedures, etc.).

Medication Administration Record (MAR, Medication record, medication sheet, med sheet): These records list all prescribed medications, along with the administration times and dosages, and actual medication administered along with the administering staff. These records are becoming increasing automated with computerized ordering (computerized physician order entry systems or CPOE), bar coding, and automated dispensing systems (e.g., PYXIS or Omnicell). Medication records may be integrated with several of the different flow sheets listed above. Many hospitals have a medication reconciliation record that tracks the patient’s prehospital or usual medication throughout hospitalization. Medication administered during a cardiac arrest or other acute life-threatening event may be documented on the “code blue sheet”.