POINT-OF-CARE MEDICAL RECORD CHECKLIST

The Joint Commission Big Book of Checklists

Point-of-Care Medical Record Checklist
Accreditation Programs/Settings: AHC, BHC, CAH, HAP, NCC, OBS, OME

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This checklist itemizes what you need to review in your ongoing audit of medical records at the point of care. During audits, you're looking for presence, timeliness, legibility, accuracy, authentication, and completeness of data and information for the items listed. You can use this checklist for those audits.

Organization: _____

Date of Review: _____ Reviewer: _____

Patient Medical Record #: _____

Items in Medical Record [AHC, BHC, CAH, HAP, NCC, OBS, OME]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticated**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
Demographic information (name, address, date of birth, sex, race, ethnicity)							
Patient identification number							
Advance directives							
Name of legally authorized representative							
Reason for admission							
History and Physical within 24 hours after registration or admission and updates							
Updated medication reconciliation form (including any medications ordered)							
Allergies (medications and food)							
Initial patient assessment							
Comprehensive pain assessments							

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Reassessments							
Initial diagnosis							
Results of diagnostic and therapeutic tests and procedures, as well as bedside testing							
Treatment goals and plan of care							
Communication needs (language needs; cultural or religious issues that could affect care, treatment, and services, noting use of an interpreter for clinical discussions)							
Communication with the patient regarding care, treatment, and services							
Informed consent form(s)							
All care, treatment, and services provided, including patient response							
Adverse drug events							
Additional diagnoses during patient stay							

Items in Medical Record *(continued)* [AHC, BHC, CAH, HAP, NCC, OBS, OME]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticated**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
All written and/or verbal orders with authorizations and timely authentications, documentation of medications ordered/prescribed, and progress notes signed and dated by the authors							
Consultation reports (entered within defined timeframes)							
Time, date, and signature for all entries [deemed status CAH, HAP]							

Items in Medical Record of Patient Who Receives Urgent or Immediate Care [AHC, CAH, HAP]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate**	**Complete**	**N/A**

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	✔	✔	✔	✔	✔	✔	✔
Time and means of arrival							
Indication that the patient left against medical advice, when applicable							
Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services							
A copy of information made available to the licensed independent practitioner or medical organization providing follow-up care, treatment, or services							

Items in Seclusion and Restraint Records *Records for restraint or seclusion use for behavioral health purposes* [BHC, CAH, HAP, NCC, OME]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
Order for each episode of restraint or seclusion							
Assessment of the patient							
Face-to-face assessment of the patient							
Shift during which each episode occurred							
Setting/unit/location where the episode occurred							
Staff member(s) who initiated the restraint or seclusion							
Length of each episode							

Items in Seclusion and Restraint Records *(continued)* *Records for restraint or seclusion use for behavioral health purposes* [BHC, CAH, HAP, NCC, OME]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
Date and time each episode initiated							
Day of the week each episode initiated							

Type of restraint used							
Any injuries sustained by the patient or staff							
Patient identifier							
Patient's age							
Patient's gender (or identifying gender)							
Use of psychoactive medications as an alternative to restraint or seclusion or to enable their discontinuation							
Documentation that supports continuation of the restraint or seclusion							
Order for continuation of the restraint or seclusion							

Items in Surgery and Other Invasive Procedure Records [AHC, CAH, HAP, OBS]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate-**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
Informed consent form(s) for procedure and sedation							
Operative and procedure reports that include the following:							
• Name(s) of the licensed independent practitioner(s) performing the procedure and his or her assistants							
• Provisional diagnoses							
• Name of the procedure							
• Description of the procedure							
• Presedation/preanesthesia assessment							
• Preinduction and/or airway assessment							
• Administration of sedation/anesthesia							
• Findings							
• Any estimated blood loss							
• Any specimen(s) removed							
• Postoperative diagnosis							

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Items in Surgery and Other Invasive Procedure Records *(continued)* [AHC, CAH, HAP, OBS]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
Postoperative report that includes the following:							
• Patient's vital signs, mental status, pain level, and level of consciousness							
• Any medications, including intravenous fluids, administered							
• Any blood, blood products, or blood components administered							
• Any unanticipated events or complications (including blood transfusion reactions) and the management of those events							
• Progress notes							
• Documentation that the patient was discharged from the postsedation or postanesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria							
• Documentation of the use of approved discharge criteria that determine the patient's readiness for discharge							

Items in Surgery or Other High-Risk Procedure Records [deemed status CAH, HAP]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
A complete and up-to-date operating room register includes the following:							
• Patient's name							
• Patient's hospital identification number							
• Date of operation							
• Inclusive or total time of operation							

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• Name of surgeon and any assistants							
• Name of nursing personnel							
• Type of anesthesia used and name of person administering it							
• Operation performed							
• Pre- and postoperative diagnosis							
• Age of patient							

Items in Discharge Record [AHC, BHC, CAH, HAP, NCC, OBS, OME]	**Present**	**Timely**	**Legible**	**Accurate**	**Authenticate**	**Complete**	**N/A**
	✔	✔	✔	✔	✔	✔	✔
Discharge diagnosis and plan (including updated medication reconciliation form)							
Discharge summary that includes the following:							
• Reason for admission (including all relevant conditions and diagnoses established during the course of care, treatment, and services)							
• Procedure(s) performed							
• Care, treatment, and services provided							
• Results of procedure(s) and any abnormal laboratory test results							
• Recommendations of any subspecialty consultants?							
• Patient's condition or functional status at discharge							
• Medications prescribed at discharge							
• Information given to the patient and family							
• Provisions for follow-up care							