Sharp Rees-Stealy Urgent Care Chart Audit Program

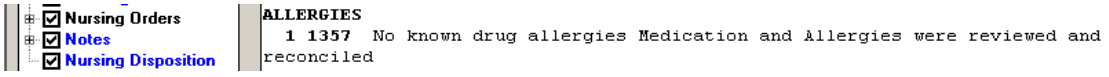
Purpose: To reinforce quality documentation through criteria that not only meets but also ensures UC behavior standards as well as high standard nursing care.

Procedure: UC chart audits are to be done once a month. 50 charts per month are audited based on 11 criteria. Charts are to be picked randomly throughout the month. It is ideal that charts are NOT collected from a concentrated day span or shift span. A good example is picking 10-15 charts a week to audit. Times of days should also be broad, for example a morning shift and an evening shift chart. Each chart is then graded on whether each criterion was met, not met, or not indicated. If a criterion is found" not indicated," simply type in NA.

Chart audits for the previous month should be done before the 10th of the present month. For example, May's chart audits should be done by June 10th. Please forward monthly totals to Nicole will input the data on a monthly basis into the Global Shared Folders (GSF) for SRS Nursing Chart Audits.

Criteria #1: Allergies entered in TouchWorks.

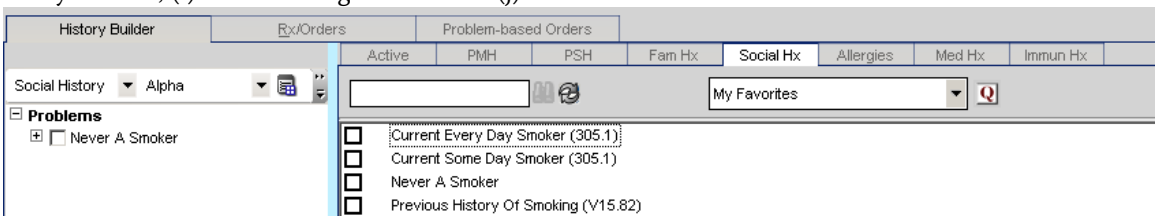
- What constitutes compliance?
  - Allergies must be consistent in MediLinks and TouchWorks.
- Exceptions:
  - None
- Examples & Points to Remember
  - Compliance
    - Nurse verifies allergies and meds listed in TouchWorks with patient, and then adds Macro "Medications and Allergies were reviewed and reconciled" in MediLinks.



Criteria #2a: Smoking history entered in TouchWorks

- What constitutes compliance?
  - Smoking status is documented in TouchWorks on all patients ages 13 and older.
- Exceptions:
  - Patient is less than 13 years of age.
- Examples & Points to Remember
  - Compliance – Simply chart smoking status on all patients ages 13 and older. Nurse assesses patient's smoking history and selects one of ten options: (a) current every day smoker, (b) current some day smoker, (c) former smoker, (d) never a smoker, (e)

smoker, current status unknown, (f) unknown if ever smoked, (g) light smoker, (h) heavy smoker, (i) uses chewing tobacco and (j) uses snuff.



Criteria #2b: Smoking Cessation Order entered in TouchWorks

- What constitutes compliance?
  - All current smokers ages 18 and older must have an order placed which documents smoking cessation materials were offered (and received) by the patient.
- Exceptions:
  - Patient is less than 18 years of age or patient denies current smoking status.
  - If patient refuses smoking information, nurse should select, "temporary deferral".

Criteria #3: Appropriate Intake Recorded (Measured weight, temperature, pulse, respirations, blood pressure, O2 sat as indicated and nursing pain assessment)

Measured Weight

- What constitutes compliance?
  - Weight on approved scale and recorded; cannot be stated weight
- Exceptions
  - Patient refuses, unable or in unstable condition to weigh
- Examples & Points to Remember
  - Compliance – simply chart the patient's weight, e.g. "150#"
  - If patient refuses, simply chart "refuses"
  - If exception is not charted, then chart must be marked off for NOT meeting criteria.
  - If exception to criteria is charted, then criteria is marked "not indicated" on chart audit.

Temperature

- What constitutes compliance?
  - Temperature is taken and recorded
- Exceptions
  - Patient is in unstable condition
- Examples & Points to Remember
  - Compliance – simply chart the patient's temp, e.g. "98.3"
  - If patient refuses, make sure to chart "refuses"
  - If patient is unstable make sure to chart "unstable"
  - If exception is not charted, then chart must be marked off for NOT meeting criteria.
  - If exception to criteria is charted, then criteria is marked "not indicated" on chart audit.

Pulse

- What constitutes compliance?
    - Pulse is taken and recorded
- Exceptions:
    - None
- Examples & Points to Remember
    - Compliance – simply chart the patient's pulse, e.g. "80"
    - If pulse is not charted, then chart must be marked off for NOT meeting criteria.

Respirations

- What constitutes compliance?
    - Respirations are taken and recorded
- Exceptions:
    - Child is crying, documentation of no respiratory distress, audible wheezing, etc
- Examples & Points to Remember
    - Compliance – simply chart the patient's respiratory rate, e.g. "18"
    - If child is crying simply chart "crying"
    - If exception to criteria is charted, then criteria is marked "not indicated" on chart audit.
    - If respiratory rate or exception is not charted, then chart must be marked off for NOT meeting criteria.

O2 Saturation

- What constitutes compliance?
    - O2 sat is taken and recorded on patients who demonstrate any compromise in respiratory function, chest pain or SOB
- Exceptions:
    - O2 sat is not indicated
- Examples & Points to Remember
    - Compliance – Simply chart the patient's O2 Saturation, e.g. "98% RA"
    - If O2 Sat is not indicated then simply leave field blank or chart "N/A", the criteria is then marked "not indicated" on the chart audit.

Blood Pressure

- What constitutes compliance?
    - BP is taken and recorded
- Exceptions:
    - Child is < 3 years old, trauma to extremity, or patient refuses
- Examples & Points to Remember
    - Compliance – Simply chart the patient's Blood Pressure, e.g. "120/80"
    - If an exception is met, make sure to chart it, e.g. "refused"
        - If child is < 3 years old, simply leave field blank or chart "N/A"
    - If exception to the criteria is met, the criteria is marked "not indicated" on chart audit

Nursing Pain Assessment

- What constitutes compliance?
    - All patients will be evaluated on either the 0-10 pain scale, Wong-Baker "faces" pain scale or by using mild/moderate/severe. This will be documented in the chart.
- Exceptions:
    - None
- Examples & Points to Remember

- Compliance – Simply chart what level of pain is OR make sure pain level is charted as described by patient, "it hurts really bad" and describing what patient looks like, e.g. 'patient grimacing, guarding stomach' etc
- If pain level or description of pain level is not charted then criteria is marked off on chart audit.

Criteria #4: Vital signs post-intervention and/or upon discharge

- What constitutes compliance?
  - Vital signs must be taken and recorded on all patients that receive invasive procedures or treatments such as IV fluids/meds, IM meds, nebulizer treatments and/or within 30 minutes of discharge.
- Exceptions:
  - Patient with > 1 hour stay
  - No invasive procedures/treatments (IV, IM, Neb Tx)
  - Provider gives verbal discharge to patient which prevents nurse from taking final set of vital signs (must chart this under 'Nursing Disposition').
- Examples & Points to Remember
  - Compliance
    - All sets of vital signs are must be properly recorded in the vital sign section of TouchWorks.
  - If discharge VS are indicated and missed, then criteria must be marked NO in chart audit.

Criteria #5: Appropriate management of abnormal vital signs and/or hypertensive patients

- What constitutes compliance?
  - Abnormal VS will be immediately reported to the provider – this will also be documented with the time VS taken and the time the provider were notified.
  - Hypertensive patients (patients whose systolic is >139 and/or diastolic >89) must have a repeat manual BP taken five minutes after the initial elevated result. The repeat manual BP must be documented within the vital signs section of TouchWorks.
- Exceptions:
  - Patient has normal VS
- Examples & Points to Remember
  - Hypertensive patients - Blood pressure guidelines
    - Recheck after 5 minute rest period by manual BP
      - Systolic 140 or higher
      - Diastolic 90 or higher
  - Abnormal parameters that require provider notification:
    - BP: systolic >179 or <90 AND / OR diastolic >109 or <50
    - Respirations: <10 or >30
    - O2 Sat: <93%
    - Pulse: <50 and >110
    - temperature adult <96 > 102
  - Immediately report abnormal vital signs to the provider (see parameters above).

- If provider notified, must chart name of provider notified.
- If abnormal VS is noted, but no documentation of provider being notified, then criteria will be marked NO on chart audit.
- If a hypertensive patient (>140/90) does not have a repeat manual BP documented, then criteria will be marked NO on chart audit.

Criteria #6: Patient visualized by staff every 20-30 minutes and kept informed of delays.

- What constitutes compliance?
  - Staff laid eyes on patient at least every 20-30 minutes and documented same. Staff kept patients informed of delays and documented this in the chart.
  - 31 minutes = late
- Exceptions:
  - Patient spent longer than 20-30 minutes in another department (lab, radiology, etc); patient in UC less than 20 minutes. Charting should reflect time and department patient is during UC visit.
- Examples & Points to Remember
  - Compliance
    - "Patient states no needs at this time. Informed of plan of care".
    - "No change in patient status".
    - "Patient to x-ray dept, ambulatory".
      - Must chart when patient returns to UC to validate patient being in another department for more than 20 minutes.

Criteria #7: Two identifiers charted for medications / treatments / interventions given.

- What constitutes compliance?
  - Two identifiers – e.g. DOB/pt name – will be documented in the nursing notes.
- Exceptions:
  - No medication(s) or treatment(s) given
- Examples & Points to Remember
  - Compliance
    - "Two patient identifiers used. Tylenol 650mg given PO".
    - "DOB and pt name verified. Vicodin 1 tab given PO".
  - In any other case, if med or treatment was given and two patient identifiers were not used, then criteria must be marked NO on chart audit.

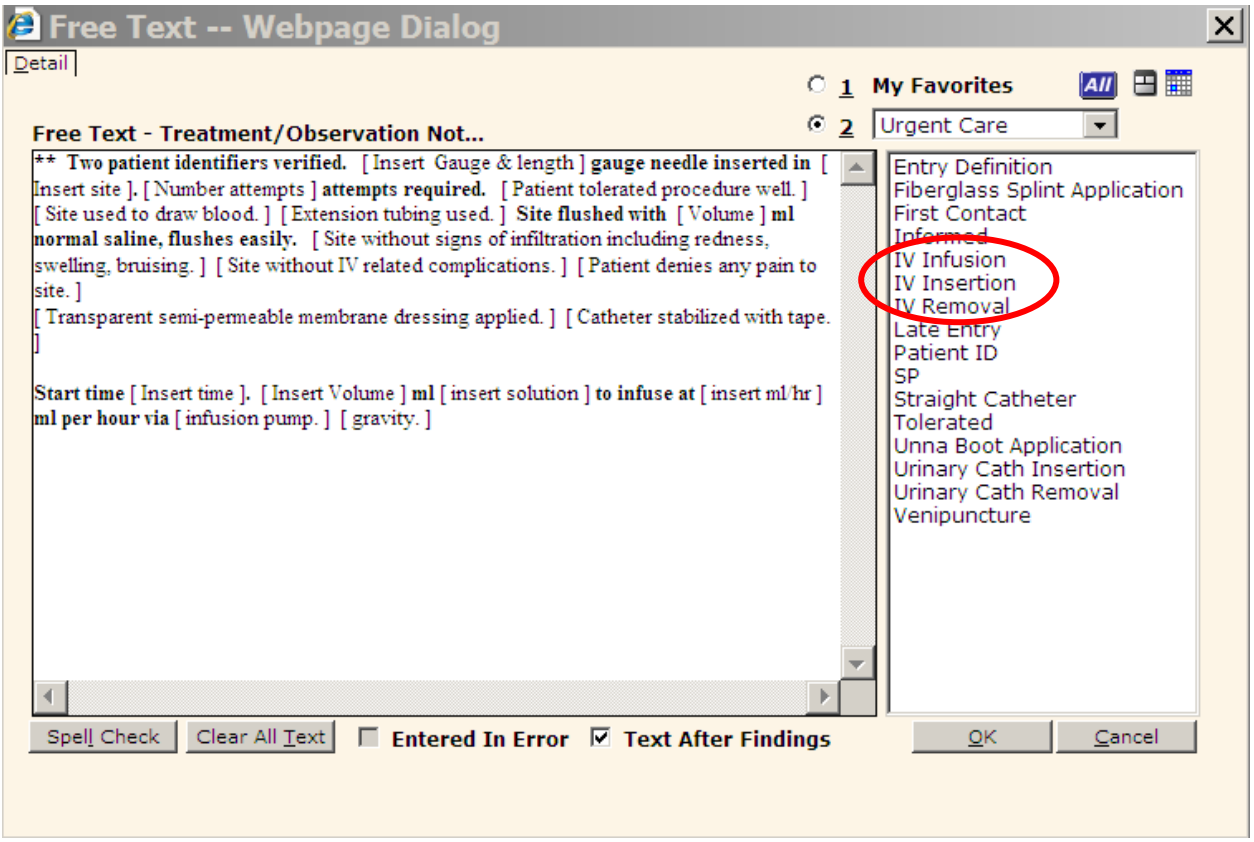
Criteria #8: Response to treatment of presenting problem documented.

- What constitutes compliance?
  - A statement describing the patient's response to any treatment(s).
- Exceptions:
  - No treatment in the Urgent Care
- Examples & Points to Remember

- Compliance
  - "Patient states pain is now 3/10". (Approximately 20-30 minutes after receiving pain med).
  - "O2 Sat – 98%, patient states he's breathing much better now". (After receiving neb TX).
  - "Patient reports no change". (Inform provider if pt came in for pain or SOB and still no change. Also document as such.)
  - "No reaction noted".
  - Or in disposition note: "Patient in no distress".
- If patient presented in acute distress (i.e. – severe pain or SOB) and still has no change in condition after treatment, inform provider right away.
- If response to treatment is not charted, then criteria will be marked NO on chart audit.

Criteria #9: IV and IV Infusion Documentation

- What constitutes compliance?
  - All patients who have IV's placed must have documented:
    - Site
    - Method
    - Medication Infused
    - Rate of flow
    - Start/Stop Times
    - Total amount infused
- Exceptions:
  - Patient did not receive an IV or IV infusion.
- Examples & Points to Remember
  - Remember if you discontinue solution to go to x-ray, etc you must chart when solution is restarted. Use two identifiers and conduct line reconciliation when restarting solution.
  - **Document Site**
    - 20 gauge IV started in LAC, 1st attempt
    - 20 gauge IV started in LAC, second attempt; blood drawn and taken to lab
  - **Document solution, amount, and rate or push time**
    - NS 1000 ml hung at 250 ml/hr, two patient identifiers used
    - IVP Toradol 30 mg over 3 minutes, two patient identifiers used
    - IVPB Rocephin 1 gm in 100 ml NS hung at 200 ml/hr, two patient identifiers
  - **Chart time infusion stopped and amount infused**
    - NS discontinued, 850 ml infused.
    - First liter of NS infused.
    - Rocephin 100 ml infused.
  - **Chart IV site discontinued**
    - IV site discontinued, catheter intact. No IV site related complications noted. Pt tolerated well.
  - All UC nurses are required to use IV text templates.



Criteria #10: If narcotics or sedatives administered, how the patient left the facility (taxi, spouse driving, etc).

- What constitutes compliance?
  - Mode of transport and driver (if POV) documented noted or disposition note.
- Exceptions:
  - No narcotics or sedatives administered.
- Examples & Points to Remember
  - Compliance
    - "Family member to drive patient home".
    - "Pt to home via taxi".
    - "Pt dc'd to hospital. Transported via CCT".
  - UC is liable for any patient given a sedative or narcotic and that patient operates a vehicle.
  - Remember if any med is given and there is a potential for any drowsiness, then this criteria must be met. Not just narcotics: e.g. Phenergan can cause drowsiness.
  - If narcotic or sedative was given to patient, and mode of transportation and driver not documented, then criteria must be marked NO on chart audit.

Criteria #11: Document Billing Provider and Performing Provider prior to charting

- What constitutes compliance?
  - Billing Provider and Performing Provider charted prior to RN Note.

URGENT CARE CHART AUDIT TOOL

DOS _____ Nurse _____ MRN _____

Criteria	Yes	No	What constitutes compliance?	Exceptions
1. Allergies noted in TouchWorks			Allergies are entered into TouchWorks.	None.
2. Smoking History / Cessation Order Entered			Smoking status is documented in TouchWorks on all pts ages 13 and older. Cessation order must be placed on all current smokers.	Smoking – ages 12 and under.
3. Appropriate intake recorded			Appropriate intake – measured weight, temperature, pulse, respirations, BP, O2 Sat as indicated, & pain assessment.	Refused, Unable, or in Unstable Condition
4. Vital signs during / post-intervention			Taken and recorded High Acuity IV Hydration	Verbal discharge to patient.
5. Appropriate management of abnormal vital signs and/or hypertensive patients			Abnormal vital signs will be immediately reported to provider and documentation to reflect specific provider name as being made aware of abnormal vital sign(s). Hypertensive patients (>139/89) must have repeat manual BPs documented.	Patient has normal vital signs.
6. Patient visualized by staff every 20-30 minutes and kept informed of delays			Staff rounds on patients every 20-30 minutes, keeps them informed of delays, and documents accordingly.	Patient spent longer than 20-30 minutes in another department (lab, radiology, etc…); patient here less than 30 minutes.
7. Two patient identifiers charted with medication name, test or treatment during administration			The use of two identifiers- e.g. DOB/pt name- and the name of the medication, test or treatment will be documented in the nursing notes.	No medications or treatments given.
8. Response to treatment of presenting problem documented			A statement describing the patient's response to any treatment(s).	No treatment in Urgent Care
9. IV and IV Infusion Documentation			All patients who have IVs placed must have documented: site, method, medication infused, rate of flow, start/stop times, total amount infused. Nurse to use TW text template.	Patient did not receive an IV or IV infusion.
10. If Narcotics or Sedatives administered, how the patient left the facility. (Taxi, spouse driving, etc…)			Mode of transport and driver documented in disposition note.	No narcotics or sedatives administered.
11. Document Billing Provider and Performing Provider prior to charting			Billing Provider and Performing Provider charted prior to RN Note. Audit trail reviewed during chart audit.	None