UTImportant Electronic Medical Record Navigation Points for Joint Commission Surveys

1) Determination of the existence of an advance directive
2) Informed consent forms (even if scanned in)
3) Nursing Admission Assessment to include:
    a. Nutrition screening
    b. Functional screening
    c. Abuse screening
    d. Fall Risk screening
    e. Pain screening
    f. Braden Scale score
4) Pain Reassessment after intervention
5) Respiratory Therapy initial assessment & reassessment after intervention
6) Primary language spoken
7) Ethnicity of the patient
8) Documentation of daily weight if ordered
9) Critical Test result identification
10) Documentation of physician notification of critical result
11) Documentation of plan of care, goals, updates
12) Learning needs assessment
13) Surgical or Procedural patient
    a. Informed consent
    b. Pre-procedural checklist
    c. Pre-anesthesia/sedation assessment to include plan, airway classification and ASA score
    d. Time-out (time must be documented)
    e. Post-Anesthesia assessment
    f. Procedural medication administered
    g. Immediate post procedure note
    h. Operative report
14) Restraint Patient
    a. Timely order, appropriate order thereafter (4 hours for BH Restraint & 24 for Non-BH Restraint)
    b. Documentation of behavior prior to restraint intervention
    c. Evidence of monitoring of patient according to policy
    d. Modification of the plan of care
15) Medical history and physical examination
16) Update to the History and Physical for outpatient procedures
17) Psychiatric evaluation for inpatient psychiatric patients
18) Referral Assessments
    a. Physical Therapy initial evaluation
    b. Occupational Therapy initial evaluation
    c. Speech Therapy initial evaluation
    d. Recreation Therapy Assessment
19) Dating and timing of all paper entries