PROTOCOL FOR: **Chart Review and Audits (Inpatient)**

POLICY:

1. A licensed nursing staff member must review every patient chart at least one time per 24 hours.

   a. ICU and NICU: a chart review will be completed every shift.

2. Unit-specific structure standards define the time of day/shift when chart review is done (for example, night shift on Med 4 and Surgery 7, evening shift in Newborn Nursery).

3. The chart review will be documented on the Inpatient Daily Chart Check form, which will be kept in the front of each patient chart until the time of discharge. This form is initiated as soon as possible after admission. The chart review will consist of:

   a. Reviewing all orders written since the previous chart review.

   b. Checking for accuracy of all transcribed orders on:

      1) MAR
      2) Infusion Record (included on MAR and POE units)
      3) Kardex (except POE units)
      4) Diet sheet (except POE units)
      5) Lab Sheet (on units with morning phlebotomy rounds)
      6) Nursing Rounds Report (POE units only)

   c. Verifying that the patient care plan (SCP, carepath, treatment plan) is updated:

      1) Active protocols/interventions have been initiated.

      2) Resolved problems/interventions have been closed out.

   d. Verifying that the Patient and Family Teaching Record has been initiated and updated to reflect the documentation of teaching that has occurred, to identify current learning needs, and to identify items that require additional teaching.

   e. Ensuring that the database has been initiated and/or completed. Patients who have been admitted from UCONN Procedures Center or the ED will have electronically-completed core databases.

   f. Ensuring that progress notes have been written according to the procedure for Documentation: Progress Notes.

   g. Verifying that identified unit-specific charting issues have been completed according to protocol/procedure.

4. If any of the above documents are absent and/or incomplete, it is the responsibility of the RN completing the review to initiate and/or complete to the best of his/her ability and to communicate further documentation needs.

5. Documentation of chart review will be indicated by writing “Chart reviewed/signature and credentials/date and time” after the last written order of the physician/LIP order sheet.
6. For units using Physician Order Entry (POE), the review of orders

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will be done electronically through the POE system.

a. Infusion record and diet sheet are not used.

b. Kardex is replaced by the nursing rounds sheet.

7. Weekly audits will be completed on each unit and documented on the Inpatient Chart Audit Form.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 9/06

REVISION DATES: 3/08