

## ➔ **Medical Record Review:** ▲

Purpose - To verify the provision of safe, effective, interdisciplinary care through the staff documentation in the patients' medical records

**Review the medical records for all the sampled patients** *selected during Patient Sample Selection - All of the medical record reviews are focused reviews, looking at the care provided to each sampled patient in the area/rationale used to select them. Review each sampled patient's dialysis/medication orders, and the documentation of their dialysis treatments. The remainder of each patient's medical record review should be focused on the components of the record related to the area/rationale for sampling that patient, using the following guidelines:*

**Dialysis prescription/medication orders and dialysis treatment records for all sampled patients** (except closed records of patients involuntarily discharged): *Review the patient's current dialysis prescription and medication orders and compare to the documentation of the dialysis treatments delivered:*

- **In-center HD patients** - Look at 2-3 consecutive weeks of hemodialysis treatment records for machine safety checks, treatments & medications delivered as ordered, blood pressure/fluid management and patient monitoring per policy.
- **Home HD patients** - Look at 2-3 consecutive weeks of hemodialysis treatment records for staff monitoring of the patient's adherence to treatment & medication orders, machine safety checks, blood pressure/fluid management and recognizing and addressing issues.
- **PD patients** - Look at 8-12 consecutive weeks of PD documentation e.g., flowsheets for staff monitoring of the patient's adherence to treatment & medication orders, blood pressure/fluid management, and recognizing and addressing issues.

**Patients sampled due to poor outcomes, i.e., not meeting goals, in the data-driven focus areas for the survey:** *Review the patient's trend in outcomes in that data-driven focus area, e.g., 3 months of labs. Look at the physician's orders, interdisciplinary progress notes, patient care plans, and other applicable medical record components to assess the facility's actions for monitoring the patient's outcome(s), recognizing when a problem exists or a goal is not reached, and taking action to address it.*

- Expect to see that one or more IDT members were monitoring the patient's outcome in that area, recognized that the patient was not attaining their goal or had a problem in that area, and took actions toward improvement/resolution.

**Note:** *This is a focused review intended to look at facility systems for addressing poor patient outcomes in the data-driven focus areas. You are not expected to search each patient's record for all of their outcomes. If, during your review of the data-driven focus areas used for selecting that patient, you discover poor outcomes for the patient in another area, follow the guidance above for that area, as well.*

**Guidance for review of patients sampled due to anemia management concerns** as a data-driven focus area of the survey: **Patients with Hgb <10 g/dL:** *Look for evaluation of the patient for: treatable causes of the anemia, e.g., infection, inflammation, GI blood loss; iron studies such as ferritin, transferrin saturation; symptoms of anemia; erythropoiesis stimulating agent (ESA) prescribed or increased; avoidance of transfusion*

**“Unstable” patients** - *Review the IDT documentation in progress notes, physician's orders, assessments, results of physical and mental functioning surveys (KDQOL-36 or other age-appropriate survey), plans of care, etc. pertaining to the two most recent patient assessment and plan of care periods. The IDT*

***process and content of the patient assessments and plans of care are more important than the format or timelines.***

- Expect to see that an assessment of the patient was conducted and the clinical and psychosocial issues that contributed to the patient's instability were addressed through revised plan of care interventions. There should be evidence of a functional IDT process, including substantive contributions from and communication among all required IDT members.

**Newly admitted patients (<90 days) - Review the admission orders, labs and progress notes. Look at the process for assuring the new patient was appropriately evaluated on admission, prior to the first dialysis treatment, and during his/her first weeks receiving care at the facility.**

- Expect to see that the patient had written orders by a physician or non-physician practitioner (if allowed by state law) and was evaluated by an RN prior to their first dialysis treatment at the facility. The patient must be evaluated for hepatitis B and tuberculosis and offered hepatitis B vaccination and pneumococcal vaccination, if indicated. The facility staff should have evaluated and addressed the issues related to the patient's labs, fluid management, dialysis-related problems, as well as other clinical, nutritional, and psychosocial needs. For home dialysis patients and their partners, their training and home dialysis environmental needs must be evaluated and addressed.

**Home HD and PD dialysis patients - If an interview with patient or staff indicates possible concerns related to inadequate training for the patient and/or caregiver, review documentation of training.**

- **Home HD patients:** In addition to the above areas applicable to a sampled home HD patient, review documentation of water/dialysate chemical and microbiological quality, as applicable for the hemodialysis equipment in use.
- **LTC residents receiving home dialysis at the LTC facility:** If there are long term care (LTC) residents on census who receive home hemodialysis or peritoneal dialysis treatments at the LTC facility, follow the current CMS Survey and Certification guidance for review of the care of the LTC resident receiving home dialysis at the LTC facility.

**Involuntarily discharged (IVD) - An IVD of a dialysis patient, i.e., no transition of their dialysis care to another outpatient dialysis provider, is a grave situation, because the patient has no reliable means for obtaining their dialysis treatments, and may expire as a result. The primary focus of your investigation for a patient who has been involuntarily discharged should be on the meaningful actions taken by the facility in attempt to avert the IVD, and to preserve the health and safety of the patient.**

**Note:** The ESRD Conditions for Coverage severely limit the option of involuntarily discharging a patient without transferring the patient's care to another outpatient dialysis facility. When one of the criteria for consideration of involuntary transfer/discharge listed at V766 is identified, the facility and ESRD Network are fully expected to exhaust all resources to address the problems and prevent the patient's transfer or discharge. If there is no resolution, the facility must make meaningful attempts to transfer that patient's care to another outpatient dialysis facility without regard to facility ownership. The only exception to this expectation is in the case of an immediate severe threat to the health and safety of others when the facility may utilize an abbreviated IVD procedure. For more information, refer to the current CMS Survey and Certification guidance on "Dialysis Admission, Transfer and Discharge Practices"

**Review the documentation pertaining to the actions taken in attempt to avert the IVD, to locate and arrange for the transfer of the patient's care to another dialysis provider, and, if all meaningful efforts are unsuccessful, the procedures followed prior to discharging the seriously abusive/disruptive patient. You may need to *interview* the facility qualified social worker and other applicable staff to supplement and/or support the medical record review.**

**Guidance for review of IVD of the seriously abusive/disruptive patient:** *Note: Patients' rights protect a patient's right to refuse treatment. Therefore, skipping or shortening treatments and/or failing to meet facility set goals for clinical outcomes, as well as verbal outbursts that do not express a credible threat are not acceptable reasons for involuntary discharge.*

**Review of the medical record and other documentation must show written evidence of/that:**

- The IDT took meaningful actions to attempt to avert the IVD. *At a minimum, these efforts must include a full IDT reassessment of the patient involving the professional IDT, the medical director, and patient's attending physician to investigate and determine the root causes of the patient's disruptive or abusive behavior and actions to resolve the issues **before** considering involuntary discharge of the patient. The facility investigation should include evaluation of possible roles mental illness, cognitive impairment, cultural or language differences or staff behaviors and interactions with the patient may play in the patients' problematic behaviors, with interventions implemented to address and resolve the conflict(s).*
- The facility staff contacted and collaborated with the applicable ESRD Network to resolve the problems, avert the discharge, and, if unsuccessful, facilitate a transfer to another facility.
- The facility staff contacted other dialysis facilities including those outside their corporation to attempt to transfer the patient before considering IVD. The patient's information shared with the contacted facilities was limited to the medical record contents per HIPAA requirements.
- The facility fully implemented/conducted ALL of the above actions **before** proceeding with the procedures for IVD.
- Once the decision for IVD was made, that the facility notified the patient at least 30 days before the IVD, notified the applicable ESRD Network, obtained a written physician's order for the IVD, signed by the medical director and the patient's attending physician, and notified the State survey agency of the IVD.

**Triggers for citation or more investigation of concerns in Medical Records Reviews:**

- Lack of evidence of a functional IDT process to monitor, recognize and address barriers to attaining identified patient outcome goals in one or more clinical and psychosocial areas
- Patient or caregiver interviews indicate lack of functional patient education program and patients' rights concerns - **Extend** review to documentation of patient education and patients' rights
- Incomplete, inaccurate, inaccessible or insecure medical records **Extend** to look at medical records systems (V726)
- Concerns identified in other survey tasks which can be investigated further through medical record review to support or dispel findings

**Extending** medical record reviews may include review of additional patients' records focused on the area of concern and additional interviews for clarification.

