

Forum of ESRD Networks Medical Record Model

Note:

The Forum of ESRD Networks, working through the Quality Improvement Directors, has developed and endorsed this Medical Record Model for use by dialysis facilities. The goal of this Model is to enhance quality care by promoting consistent content for medical records. Although use of this Model is not mandatory, it is hoped that dialysis providers will voluntarily adopt the Model for use within their own programs.

The Medical Record Model defines the components necessary to achieve a consistent approach to ESRD medical records, thereby decreasing the fragmentation that frequently occurs in the medical records of ESRD patients.

It was developed using existing guidelines, standards and ideas regarding medical records, with input from the major nephrology professional organizations, the 18 ESRD networks, and dialysis facilities around the country.

All medical records should be completed in accordance with applicable state laws.

Developed: 4/1993
Revised: 8/2001
Approved by BOD: 10/2001
The Network 18 Medical Review Board revised this document to meet current community practice & language: 12/05/07
Revised: 12/15/2008

Recommendations: Content of Active Records

Identifying Information:

- Name
- Address
- Telephone #
- Date of birth
- Sex
- Race
- Ethnicity
- Primary ESRD diagnosis and Secondary diagnosis
- Current co-morbid conditions
- Attending nephrologist name & phone number
- Facility patient registration #
- Date/type of first renal replacement therapy (first acute, chronic, location)
- Date of admission to current facility
- Next of kin/significant other
- Emergency contact person & phone number
- Social security #
- HIC (Medicare) #
- Copy of patient's driver's license and Medicare or insurance card
- Allergy stickers/information

Computerized Records

- Acceptable, if they meet all requirements of paper records (i.e. confidentiality and retention laws)

Consents and Notifications

- Informed consent for treatment
- Informed consent for reprocessed dialyzer (if applicable)
- Informed consent for blood transfusion
- Receipt of "Patient Rights and Responsibilities"
- Receipt of "Patient Grievance Form" and process information
- Receipt of ESRD Network grievance / contact information
- Release of records form
- Medical records request form
- Advance directives forms (e.g. DNR), or documentation that issues have been discussed and/or information received when applicable
- Hepatitis and other vaccination consent forms (if applicable)

History and Physical (done by physician extenders)

- Initial H&P to include:
 1. Previous health history, including hospitalizations, procedures and other medical diagnoses
 2. ESRD history, including predialysis lab data (BUN, Cr, electrolytes, serum albumin, hemoglobin/hematocrit minimum), uremic symptoms, justification for need for renal replacement therapy

- Annual exam by primary/attending physician, including review of systems and current problems
- Current history and physical should be included within 2 weeks of initiation of renal replacement therapy and/or admission to the facility, and included in the patient's record. (Also include amputations)

Assessments/Evaluations

- Initial: within 30 days of admission to facility
- Nursing, social worker, dietitian
- Annual update by social worker & dietitian

Transplantation Status

- Treatment options discussed & documented
- If patient not candidate, reason/choice documented on record

Hospitalization Records

- Admission history and physical
- Hospital discharge summary (If not obtained, a physician summary of each hospitalization should be completed.)

Language Translation

- In some states/counties, health facilities are required to provide information/education to patients in their native language. Check for state and local requirements.

Miscellaneous

- Medical record checklist
- CMS 2728
- Insurance information
- Correspondence
- Transient dialysis information

Progress Notes

Progress notes should provide an accurate picture of the patient, which reflects changes in patient status, plans and results of changes in treatment regimen, diagnostic testing, consultations, unusual events, etc. Either single discipline or integrated multidisciplinary progress notes may be utilized. The following are minimum entries:

- Each discipline (physician, nurse, social worker, dietitian) should record the progress of the patient at regular intervals or more often per facility's policy:
 1. Monthly: Unstable patients*
 2. Quarterly: Semi-annually
(6 months) - Stable patients*
(*as defined by facility or physician)
- Patient condition and response to treatment noted on daily treatment record
- Regular review of abnormal labs/clinical findings and any action taken

- Monthly review of laboratory results (including adequacy) & hepatitis status
- Vascular Access Assessment

Patient Education (routine or facility-specific)

- Disease, treatment, modality options, access care
- Services available
- Emergency preparedness: initial, quarterly or semi-annual
- Vaccine Information Statements (VIS) - required

Problem List (optional)

- Initial
- Updated as needed, at least minimum annual review
- Either separate or integrated cumulative list of patient's medical, psychosocial, nutritional problems

Comprehensive Multidisciplinary Patient Assessment (CMPA) and Patient Plan of Care

- CMPA
 1. Initial (within 30 days)
 2. Reassessment (within 90 days)
 3. Current year, annual update
- Patient Plan of Care
 1. Reflects interdisciplinary approach and based on CMPA findings
 2. Monthly for unstable patients
 3. Annual updates are acceptable for stable patients (refer to V520 for the minimum criteria for stable vs. unstable patients).
 4. The implementation of updates to the plan of care must be completed within 15 days of the reassessment.
 5. Prior 12 months in active record
- Significant change in medical status or modality
- Advanced care planning, clinical end of life directives annual update
- Patient's signature (or responsible party) – reflects participation

Physician Orders

- Standing Orders (i.e. emergency procedures, cramp management): (initial, annual update minimum)
- Dialysis prescription and medication update (initial, annual minimum). Include EPO/iron
- Post-hospitalization update (current 6 months of orders in active record minimum)

Medication Record

- Initial
- Update
 1. Whenever changes occur
 2. After hospitalization
 3. Annually (minimum)

4. Reviewed at monthly intervals, including:
5. Name of drug
6. Dose
7. Route of administration
8. Date ordered
9. Any changes to be dated
10. Drug allergies
11. All facility administered medications will be updated in the medical record, flowsheets, if such flowsheets are utilized by the facility (medication lists for outpatient, home meds may be separated from in-center meds)
12. Other allergy alerts (e.g. latex, food, etc.)

Daily Treatment Records

- May be kept separately
- Current year readily available (past 12 months)
- Filed separately for each individual patient

Consults

- Reports/letters from consulting physicians (past 12 months or readily available)

Vascular Access Record

- Type of access (if catheter, specify type, length, etc.)
- Date of insertion/creation/revision/declotting
- Reports on any access surgeries or interventions
- Name of surgeon(s)/Interventional Radiologist
- Diagram of location, flow direction, configurations
- Monitoring records (e.g. pressure run charts, recirculation, etc.)

Laboratory

- Past 12 months on active chart (or readily available)
- Cumulative lab records acceptable, original reports must be included in a permanent record if cumulative record is not generated by original laboratory. (Lab normals/reference ranges)
- Flowsheets (e.g. clotting times, adequacy of dialysis testing, recirculation studies)
- Patient-specific run charts (optional), and adequacy calculations

Transfusion Record (past 12 months)

Diagnostic Studies (past 12 months)

- Radiology, nerve conduction, bone densitometry, EEG, current and prior EKG

Preventive Care Measures

- Vaccination Status (HBV, pneumococcal, flu)
- Exams: mammography, PAP smears, retinal & foot exams (diabetics), etc.

Transient Records

- Identifying information (refer to Active Records)
- Most recent physician's orders, to include dialysis prescription (dialyzer type, reuse practice, BFR/DFR, treatment time, dry weight), EPO dose and route, dosages of other intradialytic medications)
- Most recent progress notes
- Most recent problem list (include special needs)
- Current history and physical (include cause of ESRD)
- Medication record
- Most recent laboratory (past 2 months), to include: albumin, alkaline phosphatase, BUN, Ca++, Cl-, CO₂, creatinine, LDH, SGPT, SGOT, total protein, Hgb, glucose or HgBAIC (if diabetic), PT (if on Coumadin), Hepatitis status (within 12 months)
- Last six treatment records
- Most recent comprehensive multidisciplinary patients assessment (CMPA) and Patient Plan of Care
- Most recent psychological (or social worker) evaluation
- Insurance information
- Chest X-ray and EKG (within last 12 months)
- Facility-specific forms for reporting transient dialysis experiences back to home unit
- HBV status (antigen positive or immune)
- Type of vascular access, location, flow diagram
- Emergency contact (local)
- Phone number of primary nephrologist
- Allergies
- Advance directives

Closed Records (transferred, transplanted, recovered function, withdrew from therapy, expired)

- All Records, must include:
 1. Treatment records and thinned records
 2. Additional confidential files (e.g. HIV if kept separately)
 3. Business file may be kept separately
- File Chronologically in sections, as outlined in Active Record Recommendations
- Discharge Summary - Clearly identifies the disposition of the patient (final diagnosis/cause of death, date of discharge/death, location of death, CMS 2746)

Maintained per state law, and actual chart (or copies for satellite facilities) should be available within two weeks. Check state law for minimum requirement for record retention time frame (7 years in California, longer for minors).

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Medical Review Board Statement for Inter-Facility Transfer of Patient Records

Federal “Interpretive Guidelines” (used by state surveyors): 42 CFR 405.2137, states “When a dialysis patient is transferred, the dialysis facility releasing the patient must send all requested medical record information to the receiving facility within one working day of the transfer”. The intent is to maintain continuity of care whenever patients leave the facility temporarily (e.g. vacation, business, hospitalization) or transfer permanently to a new facility.

Standard

When a patient is transferred from one renal care facility to another within ESRD Network 18 (as a transient or permanent transfer), the following medical record forms (or copies as appropriate) must be sent to the new facility:

1. Patient insurance and other identifying information
2. Medical Evidence Form (CMS #2728)
3. Comprehensive Multidisciplinary Patient Assessment (CMPA) and Patient Plan of Care
4. History and Physical (current)
5. Recent lab report (prior month), diagnostic tests (e.g. chest x-ray, EKG)
6. Recent (last six) dialysis treatment records
7. Recent (within 3 months) multi-disciplinary progress notes (dietary & psychosocial evaluations)
8. Current physician orders
9. Current medication record
10. Current problem list
11. Any other facility-specific forms for reporting transient dialysis facility experiences to home unit

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