ESRD MEDICAL RECORDS: A NATIONAL MODEL

The National Forum of ESRD Networks is an organization of ESRD professionals, whose purpose is to serve as a Forum in which assistance, advice, information, ideas and policy proposals may be exchanged between and among the Networks, the Centers for Medicare & Medicaid Services (CMS), and the Renal Community. The philosophy of the Forum is that by fostering cooperation and communication between ESRD Networks, the Congress, CMS, and other ESRD related organizations, optimal (measurable) standards for the delivery of care to ESRD patients can be defined and implemented.

Serving in this capacity, the Forum Quality Assurance Committee developed a Quality Assurance Position Paper in August 1989 which was adopted by the Forum of ESRD Networks at the April 1990 meeting in Washington DC. The development of "standards for the content of the patient care record" was included as one of the several recommendations. This position paper was submitted to CMS and generated a formal response which encouraged the development of medical record standards from Richard H. Husk (former) Director of the Office of Peer Review.

Utilizing existing guidelines, standards, and ideas requested from all 18 ESRD Networks, an initial draft document was developed in the fall of 1990. An Ad Hoc Committee of the Forum Quality Assurance Committee was formed in the spring of 1991 to revise and refine the Forum of ESRD Networks Medical Record Model. In the following year, the Model was revised, based upon the review and input of the ESRD Network Organizations, the major Nephrology Associations (RPA, ANNA, AAKP, NRAA, NKF's Councils of Renal Nutrition and Social Workers) and dialysis facilities throughout the country.

The Medical Record Model has been endorsed by the Forum for use by all dialysis facilities. Use of the Model is not mandatory; it is hoped that individual ESRD Networks will endorse and/or adopt the Model as a standard, that the professional organizations will endorse the Model, and that the dialysis provider will voluntarily adopt the Model within their programs. The Forum goal is to promote regionally based provider education and consistent content of medical records.

The purpose of this Model is to improve the quality of the medical record, which in turn improves the team's ability to provide care and to encourage a consistent approach to ensure that medical records contain the information necessary for continuity of patient care and qualitative review.

A primary goal of the ESRD Networks, as designated by congressional mandate and regulatory requirements, is the evaluation of the quality and appropriateness of care provided to ESRD patients in the United States. The medical record serves as the organized plan of care, and is utilized for diagnosing, treating and caring for the patient and ensures the highest level of communication among the various health care professionals providing services to the patient. The medical record is the focal point of this communication for coordinating the thinking of the entire team and providing an accurate picture of the patient's progress in realizing goals. It therefore provides the data for evaluation and documentation of the quality and appropriateness of care delivered.

This Model represents a recommended minimum medical record, which should not preclude or discourage more frequent interventions or expanded components. Professional practice standards and forms variations may acceptably combine elements, which are identified separately in this Model. Additionally, individualization would be required for some modalities and/or life cycles of the ESRD patient.

The Forum wishes to emphasize that the Model is subject to continuous improvement and is clearly evolutionary in nature, and will therefore, be revised to reflect future trends in the delivery of health care and/or the approach to quality management. The need for definition of the stable vs. unstable patient, difficulty obtaining hospital records, and several standard of practice issues were raised by the professional organizations and dialysis facilities which, although recognized as important elements affecting the organization and maintenance of medical records, are considered beyond the scope of this Model. Further, the recommended use of the Model is to guide practice rather than constrain, unify the interdisciplinary team approach, enhance continuity of care, simplify work, Promote collaborative practice in the ESRD healthcare system and to decrease the fragmentation often observed in the ESRD patient medical record.

FORUM OF ESRD NETWORKS: MEDICAL RECORD MODEL

The Forum of ESRD Networks, working through the Quality Improvement Committee, has developed and endorsed this Medical Record Model for use by all 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 this 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.

RECOMMENDATIONS:

CONTENT OF ACTIVE RECORDS

IDENTIFYING INFORMATION:

- Name
- Address
- Telephone Number (#)
- Date of Birth (DOB)
- Sex
- Race
- Ethnicity
- Primary / Secondary ESRD Diagnosis
- Primary Physician
- Facility Patient Registration Number (#)
- Date / Type of first renal therapy (first acute, chronic, location, MD)
- Date of admission to current facility
- Next of kin / significant other
- Emergency contact person & phone number
- Social Security Number (SS#)
- Health Insurance Coverage Number (HIC#)
- Copy of patient's driver's license and Medicare card
- Allergy stickers / information

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"

- 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)
- Informed consent for administering vaccinations, i.e., Pneumococcal, Influenza, Hepatitis B.
- Informed consent for certain tests, i.e., Tuberculosis, HIV-AIDS, drugs.

MISCELLANEOUS

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

HISTORY AND PHYSICAL (Done by Physician)

- Initial to Include:
  1. Previous health history including hospitalizations, procedures and other medical diagnoses.
  2. ESRD history including predialysis lab data (BUN, Cr, electrolytes, Hgb/hct minimum), uremic symptoms, justification for need for renal replacement therapy.
- Annual exam by primary 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.

ASSESSMENTS / EVALUATIONS

- Nursing, Social Worker, Dietitian
  1. Initial, within 30 days of admission to facility
  2. Annual update

TRANSPLANTATION STATUS

PROGRESS NOTES

Progress notes should provide an accurate picture of the progress 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, and Dietitian) should record the progress of the patient at regular intervals:
  1. Monthly – unstable* patients
  2. Quarterly – stable* patients

  * *As defined by Facility/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 & hepatitis status

PATIENT EDUCATION

- Disease, treatment, modality options
- Services available
- Emergency preparedness: initial, quarterly or semi-annual

PROBLEM LIST (optional)

- Initial
- Update prn, minimum review annually
- Either a separate or integrated cumulative list of patient's medical, psychosocial, nutritional problems

CARE PLANS

- Long Term Program (LTP)
  1. Initial
  2. Current year, annual update
- Patient's signature (or responsible party) reflects participation
- Short Term Care Plan
  1. Reflects interdisciplinary approach
  2. Monthly for unstable patients
  3. Every 6 months (minimum) for stable patients
  4. Past 12 months in active record

PHYSICIAN ORDERS

- Standing orders (i.e., emergency procedures, cramp management): initial, annual update (minimum)
- Dialysis prescription and medication update: initial, annual (minimum)
- Post hospitalization update(s)
- Minimum last 6 months orders and current standing orders in active record

HOSPITALIZATION RECORDS

- Admission History and Physical
- Hospital Discharge Summary – If not obtained, a physician summary of each hospitalization should be completed.
- Consults
- Reports/letters from consulting physicians

MEDICATION RECORD

- Initial
- Update – whenever changes occur, after hospitalization(s), and annually at minimum
- Reviewed at monthly intervals including outpatient and home medications
  1. Name of drug
  2. Dose
  3. Route of Administration
  4. Date Ordered and Date Discontinued
  5. Any changes should be dated
  6. EPO, Calcijex, etc., flowsheets. If such flowsheets are utilized by the facility (medication lists for outpatient, home meds may be separated from incenter meds)
  7. Allergies, food, drugs and environmental products

DAILY TREATMENT RECORDS

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

VASCULAR ACCESS RECORD

- Type of access (if catheter, specify type, length, etc.)
- Date of insertion / creation / revision / declotting
- All access surgeries or interventions
- Name of surgeon
- 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.
- Flowsheets
  1. clotting times
  2. adequacy of dialysis testing
  3. recirculation studies).
- Patient-specific run charts (optional)

TRANSFUSION RECORD (signed and co-signed)

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

PREVENTIVE CARE MEASURES
- Vaccination Status (HBV, pneumococcal, flu)
- Exams: mammography, retinal & foot exams (diabetics), etc.

MISCELLANEOUS
- Transient dialysis information
- Insurance information necessary for admission, all other may be in business file
- Correspondence
- Medical Record checklist
- HCFA 2728
- Transplant Referral Information
- Informed Consents

CLOSED RECORDS
Applies to:
- Transferred
- Transplanted
- Recovered function
- Withdrew therapy; and
- Expired

1. Included all records (i.e., treatment records, thinned records; business file may be kept separately)
2. Filed chronologically, in sections as outlined in Active Record Recommendations
3. Discharge summary: Clearly identifies the disposition of the patient (final diagnosis/cause of death, date of discharge/death, location of death, (HCFA 2746)
4. Be maintained per state law, and actual chart) or copies for satellite facilities) should be available within two weeks
5. Additional confidential files (e.g. HIV if kept separately)
6. Business file may be kept separately

TRANSIENT RECORDS
- Identifying information (refer to Active Records)
- Most recent physician's orders
- Most recent progress notes
- Most recent problem list
- Current history & physical
- Medication record
- Most recent laboratory (past 3 months)
- Last six treatment records

- Most recent long-term care plan
- Most recent psychological (or social worker) evaluation
- Insurance information
- 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)
- Allergies

COMPUTERIZED RECORDS

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