

**GATEWAY HEALTH PLAN®
MEDICAL RECORD REVIEW STANDARDS
SKILLED NURSING FACILITY**

1. MEMBER ID	Each page in the record contains member name or member ID number.
2. BIOGRAPHICAL DATA	Personal data includes address, telephone numbers, emergency contact, marital status, etc.
3. ENTRY ID	All entries are signed, initialed, or electronically signed by the licensed professional/originator.
4. ENTRY DATE	All entries are dated.
5. LEGIBILITY	The record is legible to someone other than the originator.
6. MEDICATION LISTING	Medication listing must be up-to-date and administered medications are recorded when given.
7. PRN MEDICATIONS	PRN medications must have documentation of effectiveness.
8. ALLERGIES	The presence or absence of allergies or adverse reactions to medications must be prominently displayed.
9. NURSING HISTORY	Nursing history is present, including current medical conditions, mental status and functional status.
10. MD HISTORY & PHYSICAL	Physician's past medical history and physical exam is present and addresses the current need for care.
11. TOBACCO/ALCOHOL/DRUGS	Notation of use/nonuse of tobacco, alcohol, and illicit drugs is present (ages 14 years & up).
12. WORKING DIAGNOSES	There is a clearly documented diagnosis related to the services being rendered and to the hospital diagnosis.
13. CARE PLANS	Documentation of care planning activities related to the member's problems and needs.
14. CARE AND SERVICES PROVIDED	There is on-going documentation of specific care and services provided to the member and of any related functional limitations
15. DISCHARGE SUMMARY	Documentation of discharge planning and a discharge summary completed within 30 days of discharge.
16. SOCIAL SERVICE INTERVENTIONS	Documentation of social service interventions and outcomes.
17. CONTINUITY & COORDINATION OF CARE	Evidence of communication with PCP and/or referring physician, especially involving changes in patient status and signed orders.
18. DNR	Member's wishes for withholding or providing resuscitative measures have been addressed.
19. CARE MEDICALLY APPROPRIATE	All care must be medically appropriate and necessary, and there is no evidence that the member has been placed at inappropriate risk.
20. OBSERVATIONS	Observations are documented every tour of duty on critically/acutely ill members and every 30 days on other members.
21. NUTRITIONAL SERVICES	Documentation of nutritional needs and responses at least quarterly.
22. ADVANCE DIRECTIVE	Notation that information concerning advance directives has been offered to members ages 21 and older.